ANGLIA RUSKIN UNIVERSITY

FACULTY OF ARTS, HUMANITIES
AND SOCIAL SCIENCES

INTERCULTURAL MUSIC THERAPY WITH CHILDREN WITH ENGLISH AS AN ADDITIONAL LANGUAGE IN SPECIAL SCHOOLS

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ABSTRACT

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This exploratory study asks what factors a music therapist needs to consider when working with a child whose cultural background differs from their own. Our cultural background and worldview influence many aspects of our lives and those of the people we work with, and yet there is little music therapy research that examines the impact of cultural difference on music therapy practice, or research in which the voices of participants are heard. This is especially important given that the music therapy profession worldwide shows an underrepresentation of minority ethnic groups, as music therapists are often drawn from privileged, majority groups. This means music therapists are less likely to have lived minority experience, and be less able to practise with cultural empathy.

Qualitative methods were employed to examine three main sources of data: a review of music therapy literature, eight case studies of children who participated in music therapy in two special schools and eight parent interviews analysed using Interpretative Phenomenological Analysis. All the children included in the study came from families where English was not the first language spoken at home. They were referred for music therapy following the usual criteria in their school. Their parents attended some or all of their child's music therapy sessions and subsequently answered questions via semi-structured interviews relating to their home life, use of music and language, and their experiences of the music therapy sessions.

The themes that arose from the three sources of data: the interviews, the case studies and the literature review, were triangulated to address the research questions. The main themes coming out of this study include the importance of music therapists acknowledging their own cultural influences, the various forms of discrimination encountered by minority ethnic groups from professionals and institutions, the value of collaborative approaches with parents in music therapy and in research, and the importance of acknowledging cultural identity and cultural factors but at the same time avoiding making cultural assumptions.

Developments in intercultural practice such as cultural empathy, cultural competence and cultural safety were explored, as well as implications from the study for future research and training.

Keywords: Intercultural music therapy, music therapy with children with special needs, music therapy with families, intercultural parent interviews

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INTERCULTURAL MUSIC THERAPY WITH CHILDREN WITH ENGLISH AS AN ADDITIONAL LANGUAGE IN SPECIAL SCHOOLS

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Chapter one

Introduction

1.1 Introduction

This research project will examine the role of culture and cultural difference in music therapy practice. In this introductory chapter I explore contrasting definitions of culture to provide context to the research and clinical work. I describe my personal motivation for the research originating in three examples from my own clinical experience to introduce and expand some ways in which issues connected to culture and ethnicity can intersect with music therapy work.

The first of these settings was a special school in which 60-70% of the pupils were from British Indian and British Pakistani backgrounds. As well as a British culture, these children had other significant cultural experiences including language, music, religion, all factors that intersect with music therapy practice. The second example comes from voluntary music therapy based work in Rwanda, east Africa. This example focuses on the cultural practices in music-making itself: the role of particular instruments and players within a musical idiom. It provides an opportunity to reflect on the emotional conflicts that may be evoked between two people of differing cultural or ethnic heritage, especially when one of those is from an historically oppressed race.

The final example is drawn from music therapy in a young oncology unit serving a large, multicultural city. The young people used their music therapy sessions to explore and redefine their sense of self, which could often be eroded by their cancer diagnosis and treatment, and the hospital environment.

Following a discussion of the areas in which cultural issues intersect with music therapy practice, the research questions will be delineated with an overview of the methodology adopted for the study. The overall structure of the thesis will conclude this chapter.

1.2 Music therapy and culture

The UK is a multicultural society: in 2017, around one in seven of the population was born abroad, whilst one in ten had non-British nationality (ONS 2018). Behind these statistics there is little agreement on what it means to be 'multicultural', with the term 'culture' itself open to contrasting definitions.

The Health and Care Professions Council and National Health Service have guidelines about culturally sensitive practice, and require music therapy training courses to include teaching on this issue (Health and Care Professions Council 2014). Music is itself inextricably tied to human experience, as an artifact of culture (Shein 1984 p. 3-4). As it is our main tool as music therapists, how much do we think about the cultural significance of the music we use in terms of both our patients' and our own backgrounds? What do music therapists need to know when working with cultural difference within a therapy relationship, however, when cultural identity is such a complex issue, different for each individual, and may not be connected to the reason the patient is seeking therapy?

1.3 Defining key terms

Music therapy and related disciplines such as psychotherapy and education use a number of terms to describe the cultural characteristics of individuals and groups. A working definition for these terms is necessary to enable discussion of these complex areas.

1.3.1 Culture

This is a huge subject, the definition of which has been attempted by philosophers, anthropologists and ethnographers. The emphasis of each definition perhaps reveals as much about the research orientation of the author as it does about culture itself. Presented below are a number of conceptions of culture that feed into the research topic.

In 'Culture-Centered Music Therapy', Stige (2002) finds the following definition by the pioneering anthropologist Edward B. Tyler useful for its breadth:

> Culture or Civilization, taken in its widest ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society. (Tyler, 1871/1958, p.1 cited in Stige 2002 p.17).

Tyler attempts in this early definition to posit that the composition of a person's cultural background is complex and evolving; there is an exhaustive inclusivity to his use of the term. Elements of ethnicity, heritage and ancestry play a part, as well as religion and cultural choice, in shaping individual identities that are realised socially. Such an inclusive, broad understanding of the processes by which culture is lived and presented creates a challenge for the practitioner-researcher in determining which variables might usefully be the subject of enquiry.

Seventy years on, Kroeber and Kluckhorn provided this definition:

> 'Culture consists of patterns, explicit and implicit, of and for human behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiment in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other, as conditional elements of future action'
> (Kroeber and Kluckhorn 1952 p.181 cited by Adler 1997 p.14).

These authors draw attention to explicit and implicit aspects of culture: values and behaviours that are clear and observable, but also those which are expressed

through common, silent consent and less accessible to observers, or even take place in the unconscious of the participants and consequently are hard or even impossible to reveal. For me, this definition also contains echoes of music; the patterns of rhythms and notes and symbols of written music.

Matsumoto describes 'the set of attitudes, values, beliefs, and behaviours shared by a group of people, but different for each individual, communicated from one generation to the next' (Matsumoto 1996 p. 16). This summation captures the duality of individual experience within a group touching on the importance of simultaneous individual and group identity. The process by which culture is passed down through successive generations is also highlighted.

1.3.2 Intercultural music therapy

I have chosen 'intercultural music therapy' to be a key term of reference in this research, as opposed to other terms such as 'cross-cultural', as this offers the most helpful description to engage with the complex, changeable world of culture, and the idea of cultural worlds interacting and engaging. 'Crossing' implies the presence of a barrier to be surmounted, and this is not always a helpful analogy. Psychoanalyst Kareem uses the term 'intercultural therapy' and in his definition states,

> 'The very fact of being from another culture involves both conscious and unconscious assumptions, both in the patient and the therapist. I believe that for the successful outcome of therapy it is essential to address these conscious and unconscious assumptions from the beginning' (Kareem and Littlewood 2006 p.14).

The participants and their families in this research all live in Britain and most hold British nationality. They also identify with another nationality or ethnicity and all that represents in terms of the attitudes, values, beliefs and behaviours. These interlocking, overlapping systems are different for each individual within the family group, as well as providing commonalities that draw them together. I also, as the

therapist and researcher, identify with a number of different cultures, explicitly and implicitly, and these influences affect all my interactions with others in ways of which I am not always fully aware. This will have an inevitable impact on my role as researcher and clinician.

1.3.3 Minority ethnic groups

In the UK, many terms have been used to refer to minority ethnic groups, including 'ethnic minority', 'minority ethnic', 'black and minority ethnic', 'non-white' as well as more specific designations such as 'Afro-Caribbean' (Aspinall 2002 p. 804). While such collective terminology is sometimes useful and necessary to address, for example, inequalities in public services, 'there is little in this lexicon of terms that is not contested' (Aspinall 2002 p. 804). These broad terms can reduce large and extremely diverse groups into a single category, minimizing the differing needs and experience of individuals (p. 805). The category 'Asian' or 'Asian British' is 'a statistical construct that aggregates Indians, Pakistanis, and Bangladeshis and other small groups that differ greatly' (p. 81). It is necessary to use collective terms at times, however, and for this research I will be using 'minority ethnic groups' unless more specific terms such as 'British Pakistani' are applicable in a specific research context. Where possible, I use the terms individuals or groups designate for themselves.

1.4. Personal motivation for this research

My interest in music therapy with clients from multicultural backgrounds was realised in my first year as a music therapist. I worked in three contrasting settings and will now use these as a lens through which to examine cultural issues. In each of these three settings I will describe two key aspects that link to intercultural ways of working. I will then set out the research questions that emerged from this work, and then expand these questions in more detail.

1.4.1 Multicuturalism and soundworlds: Special school

I worked in a special school with children with learning disabilities and autistic spectrum disorders. The school was located in an area with a very high proportion of people with Pakistani and Indian heritage. This was reflected in the pupils and to a lesser extent the staff in the school. All around the school were signs of the mix of backgrounds of people in the school; greeting songs at the beginning of the day sung in south Asian languages, the sound of music in assemblies that is popular in Pakistani and Indian culture, festivals from various world religions celebrated on the noticeboards. The room I used for music therapy was also the prayer room for Muslim female staff.

As I spent time in school hearing different languages, music from other parts of the world, seeing the bright decorative fabrics of women's clothes, and smelling the scents of bhajis and curries from cookery classes, I often reflected on the similarities and differences between myself and the children I was working with. I never felt that this was a barrier, or that I was unable to relate to them as one person to another by reason of difference in our cultural background, but it made me consider the experiences of a British child in a British school who also has an additional world of knowledge and experience to myself in their everyday life; the rhythms and textures of another language, an extra musical vocabulary to myself of a different cultural tradition. I found myself wondering about many aspects of their lives and mine, and about how they might meet in music therapy.

The answers to these questions, however, were hard to find as the children I worked with had either no or very limited language. On one occasion I was told a certain child seemed to particularly enjoy bhangra music; I thought to myself would this mean he enjoyed other music with lively rhythms, or was there something about the combination of the energetic rhythms, the harmonies and the distinctive vocal style

that he liked. Did he have a particular association for this type of music? Did it remind him of home, of someone he was close to, or a favourite occasion or time of day? And could I, with my western background and training provide a satisfying musical experience for someone who has a different musical vocabulary to myself?

These kinds of questions remained an unexplored sideline to the music therapy work for mainly practical reasons. I did not feel that the cultural differences I experienced prevented me from doing effective therapy work, and pressures of time and resources meant it was not possible for me to explore them with staff or anyone else at the school. A more pressing issue was indeed one of culture, but the clash I was working to smooth was one of a culture of education meeting my therapy culture. I was the first music therapist to work at the school so I spent a great deal of time and energy communicating the way I worked (I have a psychoanalytically informed approach; this is described in more detail in section 4.6) and why I insisted on the therapeutic boundaries I did, so I could develop a good working relationship with staff. Some of my approach no doubt seemed almost at odds with some of the practices in the school, but together we were able to come to an understanding of how a music therapy service could fit into the school model.

1.4.2 Language barriers and 'white guilt': voluntary work in Rwanda

A year after qualifying as a music therapist I went to Rwanda with UK charity Music as Therapy International to train local staff in music therapy techniques to put in place a music program for the disabled children in their care. I experienced huge differences in culture, language, training and professional background. Despite this, time and again I found myself making genuine connections and experiencing real understanding with the Rwandan staff and children through the improvised musical interactions; staff members laughing with me as we watched a boy with learning disabilities leading an activity in a new and humorous way, the frustration and lack of

hope of staff for a young girl who had been neglected her whole life so had never developed speech, and feared humans.

I had learned a handful of words of Kinyarwanda, the local language, and knew basic French, but certainly not enough to communicate the complex ideas and theories I wished. Through practical demonstrations and attending to non-verbal communication, I was astounded by how much the staff members, my colleague and I could share. In some situations language barriers seemed to melt away. After six weeks of improvising music with the Rwandan staff I felt I knew a great deal about them; their characters, their emotions, interpersonal relationships, approach to a range of situations. And of course they now knew the same about me. Yet the language barrier meant that we had not exchanged much of the information we may well have done under other circumstances; our personal circumstances, experiences, hopes for the future.

Improvised music provided a shared language in which interpersonal currents of emotion and reaction could be communicated and understood fluently. When the Rwandans asked me about myself, we did not have shared cultural references so meanings were not reliable. To give two examples: Whilst not the case in the UK, car ownership would have placed me as a member of Rwanda's elite. Some of the staff members would have owned the same number of possessions I had brought with me in my rucksack for seven weeks. I did not wish to tell my Rwandans colleagues about my car-owning, possession-filled life back in the UK because I felt knowledge of these differences might create another barrier between us.

Although music is certainly linked in many complex ways with culture, improvised music seems independent of some of these cultural markers. During a music group in the music room in Rwanda, we all recognized the music increasing in intensity,

becoming faster and more exciting; we all started moving more quickly, looking around the group more urgently, eyes wider, heart rates increasing, smiling more frequently. We were undoubtedly creating and sharing the building emotion, even though afterwards we would not be able to discuss our shared experience. More importantly, the staff members saw the potential of improvised music to give the children they cared for new possibilities for personal development: They understood our aims and had pride in their eyes when my colleague and I showed them a video clip from the morning's session of a painfully shy child confidently leading a musical activity. The musical interaction from the video clip spoke most eloquently for itself, and in a more effective way than any description could have done.

Subsequent trips to Rwanda showed me more about the place of music in the culture of that particular group of people. I was particularly struck by how much more people participate in live music than I see in my own country. At a meeting for parents of the children at the centres my colleague and I had been working at, the parents were asked by the Rwandan staff to sing a welcome to our team from the UK as is customary. The group of around seventy parents immediately sang, danced and clapped a greeting song, with one person leading and the rest of the group responding with a refrain. They seemed much more comfortable singing and dancing than I imagined an equivalent group might do in the UK, and they added harmonies and counter-rhythmic clapping before all ending together in a very sensitive way.

A number of music therapists have done work requiring travel to a different country and immersion in a different culture, and of course there are music therapists practicing in the UK who have come from and/or trained abroad. Many overseas students come to the UK to train as music therapists then return home to practice. When I joined the project I knew I would be working with people from rural south-west Rwanda and took specific language and culture lessons to support my work. In

the examples above, the music therapists were making a deliberate choice to engage with another culture. This thesis, however, is going to look at some of the issues around working with people who happen to be from a different cultural background to themselves; who came to them through the usual referral route (that is not connected to ethnicity, for example specific work with refugees) and in addition have this element of cultural difference.

'White guilt' is part of the sub-heading above, and the original use of this term refers to 'the guilt experienced by whites over the unfair advantages they owe to racism' (Gans 2006/2007). Rwanda's former colonial leaders' racial policies contributed to the tensions between ethnic groups and a series of genocides in the twentieth century. On several occasions in Rwanda I was treated deferentially in terms of my supposed wealth or status or knowledge. This made me feel uncomfortable as I felt and wished to be treated as an equal, and as an individual in my own right. I recently attended a play, 'Sizwe banzi is dead', set in South Africa during the era of Apartheid. As we reached the entrance to the theatre one of the actors, a tall black South African official segregated the audience in 'whites' and 'non-whites' by means of a rope to different parts of the theatre. We theatregoers, white and non-white felt discomfort in our separate seating, despite the fact we had come to the theatre to understand something of this very issue. Racial tensions and discomforts are still very much present in UK society, and can be easily evoked in many ways.

It is very common for music therapists to work with people with a wide range of ethnic or national backgrounds and cultural practices, each with different sensitivities and sensibilities around health and disability, therapy, and music. Music therapists may worry about these issues but feel unable to talk about them, wanting to tread a line between trying to find what is necessary about their patients' life and needs, but not wanting to highlight difference, create a perceived barrier or even cause offence.

As a white westerner in a remote area of a developing African country, I was constantly picked out as different: from children staring and shouting at me in the street to my Rwandan colleagues interestedly touching my skin and hair ("You grew it yourself? It's just like what we buy in the market"). I knew it couldn't be any other way, because I had chosen to travel to this far away place and I seemed very different to them. For most of the time I was enthralled by living and working in such a different environment, privileged to build relationships and have experiences not open to many. Occasionally, however, I found myself dismayed at being grouped along with a whole continent, and wished to have my individuality acknowledged.

When I was a music therapy trainee, an elderly female patient often requested that I play the piano and sing songs to her in music therapy sessions. These were mainly folk and traditional songs, and were known to us both due to our similar cultural heritage. These songs were full of associations for her and became a means for us of exploring her life, family background and experiences. Many of the songs were favourites of various family members. Another therapist, who did not know these songs, would most likely have found another way of exploring her life history, but would it have worked so well? The songs were such a useful shortcut for my patient to reflect on the family member in question. Or in fact, would this patient have found it easier to describe her connections to these songs to someone who was hearing them for the first time? Lightstone, a Canadian music therapist who describes his 'Jewishness' as an important part of his identity, worked with Jewish children and elderly people, and felt that the shared culture helped immensely in facilitating the therapy (Lightstone and Hadley 2013).

1.4.3 Culture and identity, accidental intercultural music therapy: Young Oncology Unit

My first job after qualifying as a music therapist was at a Young Oncology Unit (YOU) working with 16 to 24 year olds with cancer. As young people have not had such a long life to influence their health through lifestyle choices, the cancers that emerge have done so more by chance than with other age groups. The group of patients seemed to be randomly selected throughout society, perhaps more so than many other groups. I was struck by the broad range of socio-economic backgrounds, level of education, range of cultural heritage both in terms of level of acculturation and number of countries represented both by individuals and across the group.

16 to 24 year olds are identified as a group requiring specialist psychological support during cancer treatment (Williamson et al. 2010). Even though cancer is the main cause of death in this age group after trauma, outcomes are poorer for this age group than younger children or older adults, and theirs is the least researched age group (Carr, Robert et al. 2013). As well as the medical issues, 16 to 24 years olds are at a point of transition in their lives and social and developmental factors have particular relevance. They may have left home or be at university. The onset of serious illness may mean they need to live with their parents again, away from their peer group and the context in which they are developing their adult identity and independence (Carr, Robert et al. 2013).

A cancer diagnosis affects a person's sense of self and sense of identity in several ways. A diagnosis of a life-threatening or terminal illness can cause people to look back on their life thus far and reflect on what they have done and who they are, creating narratives that attempt to make sense of not only their journey through cancer but also the life they have lived so far (Mathieson and Stam 1995 p. 284). This identity will be formed through influences such as their family background and

the place where they grew up, the cultural interests they share with their family and friends, their religion, the music they listen to. Many of the treatments for cancer cause physical side effects that affect the appearance; dramatic weight loss or gain, hair loss, changes in the skin, tumours appearing in conspicuous places. For young people who are going through adolescence and the changes in their bodies that this brings, these changes are particularly difficult and often lead to 'low self-esteem, low morale, self-consciousness, worries about or complete avoidance of social situation, difficulties with peers, and, occasionally, threats to refuse appearance altering medication' (Williamson et al. 2010 p. 173).

The music therapy service in the Young Oncology Unit was flexible by necessity; the young people had not always planned their hospital admission, and might be required to attend a particular medical treatment when a space became available, so many of the music therapy sessions took place flexibly around these times. My role was to offer the young people emotional and psychological support through music. The patients used the sessions in different ways. Some found the music making to be an escape from what was happening to them; either the physical pain they were experiencing or the psychological pressures from their diagnosis. Others used it to express and communicate emotions through improvised music.

The music the young people chose to play, or listen to, often had explicit links with their culture. Music therapy sessions with one individual took the form of his playing the drums and rapping about his circumstances, mainly expressing appreciation for his social and medical support networks, while I accompanied him on keyboard. He had arrived in the UK just a few years before he found out he had cancer, and the rap idiom was one that was popular in his home country, where his family remained. The music linked him with home, peers and family, and gave him a way of sharing with another person his concerns and feelings about his experiences. Rapping in

music therapy sessions was the first time he had related his thoughts and feelings in words to anyone in the YOU, and from this he was then able to go on and speak to his social worker about his struggles.

Other young people chose to share the music they enjoyed in music therapy sessions, using music as a way of communicating something of themselves to me. One young man played and sung a song to me that he felt represented his cancer journey; a pop ballad that talked about overcoming a great obstacle. This song expressed very closely for him his feelings around his cancer journey, and gave him motivation to maintain a positive frame of mind and think with hope about his future. A young woman I worked with was isolated from friends and family, had little knowledge of the English language, and a very bleak diagnosis. She spent most of her time on the ward alone and withdrawn, engaging with neither staff nor patients. On two occasions I sat with her at her bedside, with my laptop connected to the internet and she played me some of her favourite music videos and clips from Bollywood musicals. Although a small interaction, this represented the most amount of time she spent engaged with any other person on the unit.

The music in music therapy sessions was particularly significant for many of the YOU patients in the way it gave them a chance to reflect on and share aspects of their identity, and often their cultural heritage. Music is able to evoke the feel of a culture in a special way. Gregory, an ethnomusicologist, notes that the main traditional uses of music, found in nearly all societies, include 'lullabies, the games of children, story-telling, work songs, dancing, music used in religious ceremonies, in festivals, in war, as a personal symbol, salesmanship, to promote ethnic or group identity, as communication within language itself, for personal enjoyment, in healing and in trance (Gregory 1997 p.123-37). Hearing a piece of music takes you to a place in a way that is different to remembering; it is a real, live feeling. Music is created out of

culture and the structure of the music and musical ensembles can reflect the structure of the culture from which it emerges, for example Peruvian pan-pipe music of the Altiplano is composed by the players sitting together as a group improvising their own tunes simultaneously. As time goes by, players will join in with the tunes they most like the sound of until a favourite democratically emerges. The societies that compose in this way also use communal processes to make decisions about governance. Similarly, western European society operates on more hierarchical models, and one of the main forms of western art music is the symphony orchestra, with its clear hierarchical structure in which every player knows their rank and role under a conductor.

The client group in this setting, due to their age and stage of life, were going through a period of transition from child to adult, whilst simultaneously undergoing treatment for serious, possibly life-limiting illness. Their musical choices related to different aspects of their experiences. Some music related to their illness, some music tied them to teenage or youth culture, and some related to their family, their cultural heritage or their country of origin. Arts therapists registered with the Health and Care Professions Council (HCPC) are obliged to 'be aware of the impact of culture, equality and diversity on practice', including 'understand the need to take account of psychological, social, cultural, economic and other factors when collecting case histories and other appropriate information (HCPC 2013). The culturally diverse group young people in this setting were exploring and forming their own emerging adult identity. My role as a music therapist in that setting was to support them through their cancer journey, according to what was most appropriate for each individual. Time and again cultural factors emerged as significant for those young people as their illness and treatment affected aspects of their identity and sense of self.

1.4.4 Reflection on the three settings

These three workplaces had 'cultural issues' in different ways, although the clinical work did not have a focus related to culture. The level of poverty and lack of infrastructure in rural south-west Rwanda meant I was working with a remarkably culturally and ethnically homogenous group who rarely travelled outside their own community and had limited access to mass media, and the issue of culture regularly arose only because I myself was from a very different culture.

The Young Oncology Unit had two criteria for patients; that they were between 16 and 24 years of age and had cancer. As a specialist unit it covered a big, mainly urban geographical area, and the patients had been selected largely at random by their illness. The patients came from a whole range of backgrounds, as may be found in any big city. The life-threatening nature of their illness often caused them to reflect upon what was the foundation of that life they might be losing; their friends, family, wider community, religion and race would often be part of this.

The population of the special school represented a less diverse group than the YOU because it was located in an area mainly populated by people of an ethnic minority. These pupils spent much of their home life immersed in aspects of their south Asian culture, but were also very much British children and shared a British culture and identity as well; the level of acculturation varied from individual to individual.

As a result of these experiences, and many others in my music therapy practice, I have found that culture can be found in the therapy room; in the music and singing, amongst the instruments, in clothing and language, in the greetings and farewells. Sometimes it is not acknowledged, and does not need to be. At other times the music therapist may use cultural knowledge and understanding as a means of

facilitating the emerging relationships, or may recognize barriers and work to overcome them and create a shared understanding.

1.5 Formulation of the research questions

As the years went on and my experiences as a music therapist grew, I continued to think about some of the issues work in these different places had brought up. I reflected especially on my experiences in the special school; many music therapists work in special schools or other settings with learning disabilities and autistic spectrum disorders, and these children will of course reflect the diverse multicultural society of the UK, but limited language will restrict reflection on these issues. This setting and some of the issues I have set out above now form the basis for this piece of research. I have decided on the following research questions:

Main research question:

> What factors does a music therapist need to consider when working with a child from a cultural background other than her own?

Sub questions:

> How do culturally informed perceptions about the function of music affect music therapy work?
>
> Music has links with cultural identity: How does this relate to music therapy practice?

I intend with these questions to explore intercultural work and the ways in which music, music therapy and culture relate to and inform each other. For the sake of simplicity I refer to the music therapist using the female pronoun as most music

therapists are female, and in the clinical work described in this thesis the music therapist (myself) is female and all the subjects are male.

These research questions will be answered in a number of different ways. Culturally informed perspectives will be examined through an Interpretative Phenomenological Analysis of interviews with parents. The impact of culture on music therapy sessions will be explored through case notes and interviews. Musical links with cultural identity are explored in parent interviews and related to existing literature identified in the literature review.

1.6 Overview of methodology

The methodology adopted for this research used qualitative strategies to explore intercultural music therapy practice in special schools. Three strands of enquiry were adopted to provide answers to the research questions: a literature review, eight research case studies and a thematic analysis of eight parent interviews using Interpretative Phenomenological Analysis

The clinical work was situated in two special schools with children with severe or profound and multiple learning disabilities and/or autism spectrum disorders. This client group constitutes a typical population for a special school. Special schools are a very common place of employment; 26% of music therapists work in these environments (British Association for Music Therapy 2014) and for this reason the research will explore the issue of culture in a workplace familiar and relevant to many music therapists.

Eight children were selected for individual weekly music therapy sessions over twenty weeks. They were selected subject to the usual music therapy referral criteria plus the inclusion criteria that English is not the first language spoken at home. (This

criterion was an attempt to select children whose home environment is influenced by another culture, and language is a marker of this). The children in these schools all had limited or no language, so to find out more about the experience of music therapy sessions from someone with a similar cultural background to themselves, the parents of the children were invited to attend music therapy sessions. Some parents were not able to attend the music therapy sessions as they were at work. The children of these parents, however, were not excluded from the study, as doing so might have skewed the parents to a particular socioeconomic group. These parents were shown video material from music therapy sessions instead.

The parents were interviewed by a research assistant; these interviews were analysed using Interpretative Phenomenological Analysis and the findings compared to the clinical notes and researcher diary. These findings were in turn examined in light of a literature review exploring existing research into culture in music therapy and related disciplines.

1.7 Overall structure of thesis

Immediately following this introductory chapter, the adopted methodology is set out. The chosen methodology is described in detail along with the rationale for the choices made. Finally it is placed in the context of existing music therapy research.

Chapter three is a review of the literature relevant to this research topic. Culture in music therapy literature; research, theory and practice is explored, as well as in the wider arts therapies and psychotherapy.

The clinical setting the research is outlined in chapter four; the music therapy approach used, a description of the settings and the client group. The eight research case studies are set out in chapter five along with reflections from the researcher

diary. Chapter six contains data from the eight parent interviews; a description of the interview process and analysis, then the tables of themes generated from the analysis, a discussion of the themes and how they relate to the research questions.

The final chapter draws together the findings from the three strands of data; the literature review, research case studies, and parent interviews. The results are triangulated in relation to the research questions. Conclusions are then drawn on the main findings, reflections on the method and limitations of the study, and implications of the research for future practice.

1.8 Conclusion

This chapter has set out the area for research: intercultural music therapy in special schools. Contested, rich and overlapping understandings of culture have been explored along with other terminology to be used in the thesis. The music therapy clinical work that inspired this area of research has been described to document the wide range of music therapy contexts in the UK and overseas, that necessitates sustained reflection on cultural assumptions. It is this range of work that informed the research questions, which in turn seek to develop music therapy practice.

Chapter two

Methodology

2.1 Introduction to the chapter

This chapter will set out the rationale for the methodology adopted in this doctoral research. Contrasting methodological approaches are outlined, and the justification for the choice of methodology for this research is given and placed in the context of existing music therapy research. Ethical and other considerations relating to parent involvement and researcher bias are outlined.

2.2 Contrasting research methodologies

Research methods can be broadly divided into two theoretical positions: quantitative and qualitative. Essentially, quantitative strategies are looking to generate statistically significant outcomes that can be generalized and replicated by other researchers and clinicians. Qualitative strategies examine the processes taking place within, for example, music therapy and the experiences of the individuals involved; clients, therapists, parents etc. This is not, however, such a clear split as it might seem; most research designs will incorporate elements of both qualitative and quantitative approaches, and many music therapy researchers choose mixed methods designs to combine the benefits of each approach, as described later in this chapter. Indeed the music therapy community needs both quantifiable outcomes based research findings and reflective, process based information to develop theory and practice. 'Both paradigms are essential for the future of music therapy practice' (Wigram, Pedersen and Bonde 2002 p. 225).

2.2.1 Quantitative research methodologies

Quantitative research has grown out of positivist philosophy, and is based in the belief that 'given appropriate methods, human behaviour can be controlled and

predicted in the same manner that the actions of inanimate objects are controlled', furthermore, 'positivists believe that findings can be generalized from one setting to another in a value-free manner' (Wheeler 2005 p.13). It is an objective approach that measures effect size rather than asking participants for value judgments.

Bryman summarises quantitative research as that which:

- 'Entails a deductive approach to the relationship between theory and research, in which the accent is placed on the testing of theories;
- Has incorporated the practices and norms of the natural scientific model and of positivism in particular; and
- Embodies a view of social reality as an external, objective reality'

(Bryman 2008 p.22)

Quantitative research designs are likely to involve 'hypotheses, manipulation of independent variables, collecting data that can be measured in some way, often comparing the effects of an intervention on a treatment group with a control group who receive no treatment, a placebo, or an alternative treatment, and applying statistical analysis to search for significant differences' (Wigram, Pedersen and Bonde 2002 p. 224). These elements create challenges for researchers; music therapists often work with individuals who may be subject to a wide range of external factors, e.g. comorbidities, complex social situations, that cannot easily be controlled within experimental designs. There may be further challenges of getting a large enough sample size to obtain statistically significant outcomes, as well as the difficulty of creating any kind of placebo music therapy treatment and ethical issues around designs featuring a control group, which must be either excluded from or delayed in receiving music therapy.

2.2.2 Qualitative research methodologies including naturalistic approach

Qualitative research, taking its origins in naturalistic philosophy:

- 'predominantly emphasizes an inductive approach to the relationship between theory and research, in which the emphasis is placed on the generation of theories;

- has rejected the practices and norms of the natural scientific model and of positivism in particular in preference for an emphasis on the ways in which individuals interpret their social world; and
- embodies a view of social reality as a constantly shifting emergent property of individuals' creation' (Bryman 2008 p.36)

This type of design 'involves formulating research questions that investigate phenomena, taking a broad view and focus, operating in a more flexible research frame, studying and interpreting human behaviour as a phenomenon, and sometimes theory building (Grounded theory) as part of the process' (Wigram, Pedersen and Bonde 2002 p.224). Qualitative strategies encompass a range of research methods such as ethnography and action research. Since qualitative methods are concerned with exploring lived experience and can include the perspectives of both subject and researcher (as this approach holds that the subject is linked to their environment and cannot be separated), this can be ideally suited to exploring aspects of music therapy practice, for example the formation and maintenance of therapeutic relationships.

Naturalism is a qualitative approach that 'seeks to understand social reality in its own terms; "as it really is"; [it] provides rich descriptions of people and interactions in natural settings' (Bryman 2008 p.367). This research follows the naturalistic model, as its data will intentionally be gathered in a typical music therapy clinical setting: a special school, rather than a laboratory or any other space designed primarily for the purpose of research. As researcher-practitioner, I will gather the data through conducting something as close as possible to their usual music therapy practice. By locating the clinical work for the research in a typical practice environment, special schools, it is hoped the results obtained will provide insights into the impact of cultural difference on music therapy practice.

2.2.3 Mixed methods designs

Despite the concern that qualitative and quantitative approaches arise from opposing philosophical standpoints, some researchers choose to combine the techniques from each into a unified piece of research. Many music therapists adopt a mixed methods strategy to obtain both the quantitative statistically significant answers from experimental data and the 'how' and 'why' of qualitative elements to add greater depth and context to their quantitative findings. According to Bradt et al, 'Combining qualitative and quantitative methods overcomes the limitations of each method alone by generating data that provides context or meaning for quantitative results, arguments from multiple perspectives, and more evidence to assist in the application of findings to clinical settings' (2013 p. 124). Schwantes investigated the effect of music therapy on the mental health of migrant workers using a mixed methods design. She chose to include a qualitative element to her research design as she wanted to find out about the experiences of the subjects in her study. She felt this would enrich her data and therefore subsequent understanding of music therapy practice (Schwantes 2011 p.109).

Pool asserts that mixed methods research stands 'between the two main paradigms of qualitative and quantitative research [thus finding] a practical solution to the research problem' (2012 p.74). Perhaps rather than existing a middle ground between the two poles, mixed methods designs allow qualitative and quantitative techniques to exist in parallel within the same research protocol, reaping the benefits of both strategies despite their different epistemological and ontological orientations (Bryman 2008 p.22).

Mixed methods approaches have some drawbacks, however, that are connected to the extra resources required for, in effect, carrying out two different research projects at once. Bradt et al (2013) set out these issues further: sampling requirements are

usually different for the two types of study; researchers using quantitative sampling require representative subjects that will yield generalizable data whereas qualitative sampling requires subjects that will provide rich data to understand the area of investigation so a compromise must be found (p. 136). The researcher requires the expertise, time and resources to carry out the research and analyse the various types of data, and also the will to defend their methodology against criticism from those who would locate their research exclusively in one paradigm (p. 137).

2.3.1 Music therapy research context

Qualitative research techniques are used commonly in music therapy research as they give scope for more nuanced understanding of the experiences of client and therapist. They seek to explore the process taking place in music therapy: 'Why is music therapy effective? How does music therapy work? What is the therapist doing? What happens within the client-therapist relationship?' (Wigram, Pederson and Bonde p. 244).

Music therapy researchers use both qualitative and quantitative approaches in their research designs; in some cases both within a mixed methods design. Wigram, Pederson and Bonde (2002) undertook an analysis of the types of research articles reported in journals produced in Britain, Scandinavia, Germany and the United States, and observed an increase in qualitative research methods (2002 p.235). Part of this trend may reflect music therapists wishing to understand their own practice in more depth as the profession matures and looks not only to research methodology evidencing the statistical efficacy of the approach. In more recent years, however, there have been a great number of quantitative research studies (Bieleninik et al 2018, Silverman 2019, Letwin and Silverman 2016) as well as further qualitative (Schmid et al. 2018, van Bruggen-Rufi et al 2017) and mixed methods research (Ettenberger et al 2017).

2.3.2 Demonstrating efficacy of the music therapy approach

Commissioners of music therapy services within the UK National Health Service are bound to provide evidence-based medicine; such evidence is ranked through the hierarchy of evidence in the diagram below:

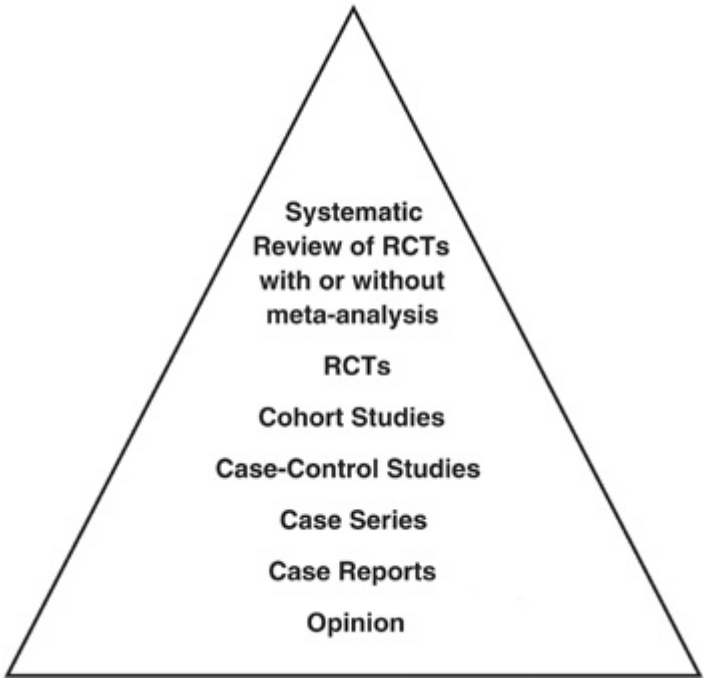


Figure 1 Hierarchy of evidence model (Akobeng 2005)

This hierarchy of evidence model places randomized control trials (RCTs), which are quantitative in design above qualitative studies, with the possible implication that these kinds of design exemplify more important research. Music therapy researchers who wish to provide evidence for the efficacy of music therapy as a clinical intervention choose a research design that will produce quantitative, transferable outcomes. As discussed above, however, music therapy research as a whole should encompass both qualitative and quantitative strategies for the fuller understanding of the profession.

2.4 Choice of methodology for this research project

The research project is exploring the subject of culture within the context of music therapy practice in special education. The research questions ask **what** does a music therapist need to consider in this context and **how** the function of music and **how** culturally informed perceptions of music can affect practice. These types of questions place this research within the domain of qualitative or non-positivist enquiry.

Ansdell and Pavlicevic (2001 p.98) suggest that the research questions should be the starting point to inform the choice of methodology, rather than taking an ideological position on methodology and subsequently applying it to the research in question. This approach was adopted by Kaenampornpan (2015) and Loth (2014) who both used their research questions to inform their literature review and subsequently their methodology. This is in contrast to Schwantes (2011) who, following identification of a field of research, used a literature review to narrow down a research focus. She then outlined her methodological approach and subsequently the research questions.

My clinical practice has informed the research questions; within my first few years as a music therapist I encountered cultural difference in sessions, which awakened my curiosity as to what, if any, impact this difference might have on the developing relationship between the patient and myself. I wanted to explore how I could learn to work more effectively when my own worldview and cultural identity as well as the theories, techniques and research on which my training was based are informed by white majority culture, which 'permeates our theories, our musical practices, our research practices, our educational practices' (Hadley 2014 p. 8).

The order in which this thesis is set out reflects the direct origins of my research in clinical practice. As I wanted to find out about my patients' experience in music therapy sessions, I required a qualitative paradigm that would allow for rich description and individual subjective responses. There is little research into music therapy and culture, and even less that features client voices; I have found no research into music therapy and culture that includes the voices of parents. This meant that the literature review was used as one of three sources of data rather than a method to refine the research questions, as shown in figure 2.2 below.

Loth's (2014) research used a number of strategies rooted in phenomenology to explore the use of the Gamelan in music therapy, in which she employed a thematic approach to analyse data from semi-structured interviews and other qualitative methods. I have used a thematic approach to drawing out information from my three sources of data; the literature review, multiple research case studies and parent interviews analysed using Interpretative Phenomenological Analysis (IPA). The IPA method involves identifying themes from the data to create superordinate themes, that draw out issues of multiple incidence. An illustration of this process and the thesis structure may be found on the following page (p. 29).

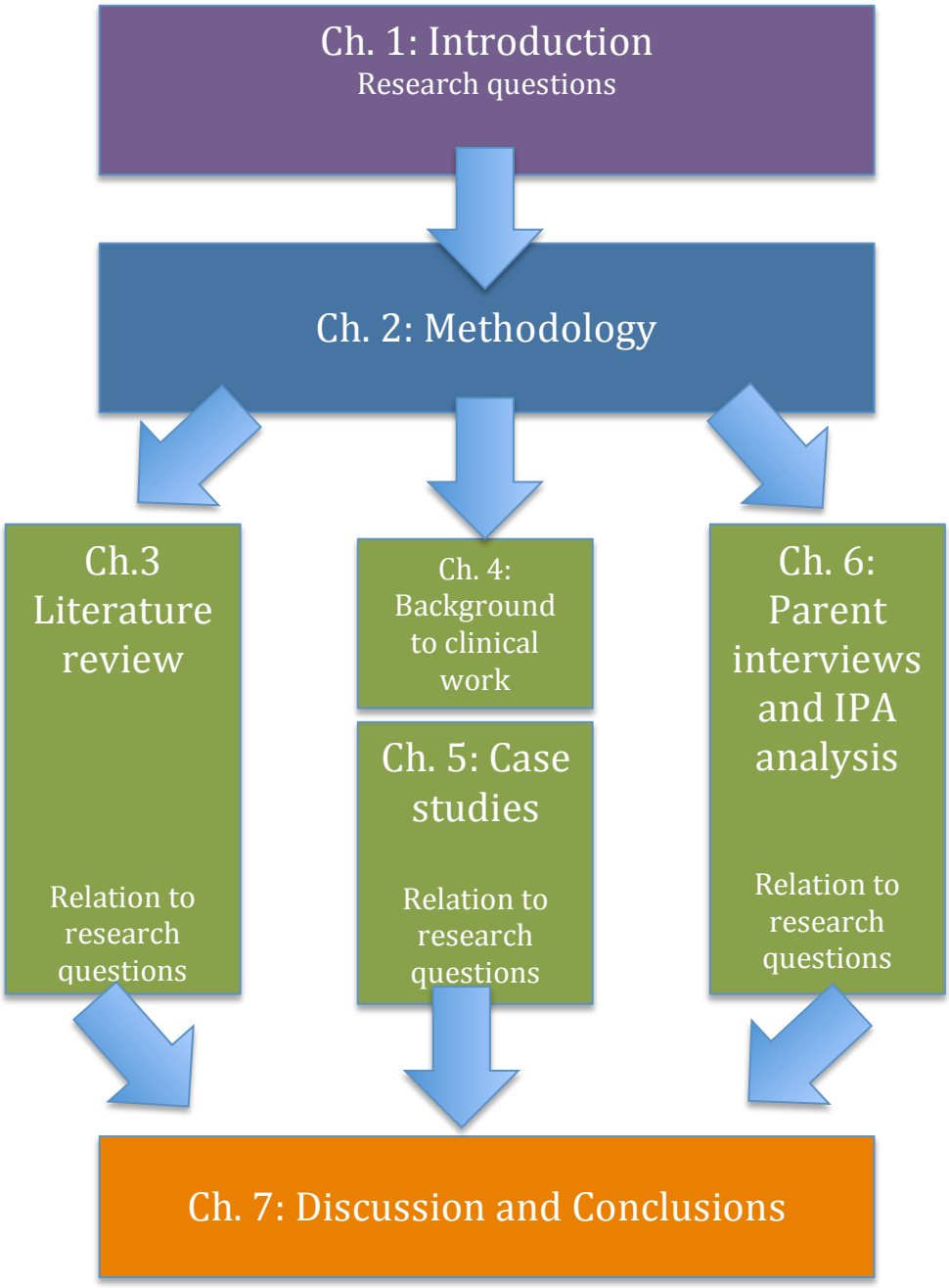


Figure 1: Diagram to show thesis structure

2.4.1 Multicultural considerations in music therapy research

The research questions for this study (set out in the Introduction chapter) seek to examine the role of culture in music therapy practice through the social reality (Bryman 2008 p.36) of both the participants and the therapist. Culture is a complex, sensitive issue, experienced and understood differently by each person. While I have

included my own definition for this and other key terms in this research, I am interested in individual participants' own understandings of culture, their own experiences of music therapy, and its relation to their understanding of culture. For these reasons a qualitative, naturalistic approach is indicated: one that will allow exploration of human experience and the way in which the participants interpret their world (Bryman 2008 p.22).

Kim and Elefant (2016) published recommendations for multicultural considerations in music therapy research. They acknowledge the small amount of existing research in this field, drawing upon a mainly white, middle-class music therapist demographic for data (p. 189). They highlighted the importance of self-awareness on the part of the clinician-researcher to minimize their own cultural bias (p. 190). They also recommended the use of a range of sources of data, including the 'etic' or outsider perspective and the 'emic' or insider perspective to allow for exploration of both (p. 193). This research uses the etic and emic perspectives of existing literature, the research case studies and parent's perspectives sought through semi-structured interviews. The combination of data drawn from three streams of enquiry recognizes the complexity of this social reality.

The researcher diary and clinical supervision are used to increase awareness of cultural bias on the part of the researcher. One of Chase's (2003) recommendations following a review of literature on multicultural music therapy practice was to use clinical supervision to explore music therapists' 'own cultural views and values and their role in the music therapy session' (Chase 2003 p. 87). Kim and Elefant (2016) consider the researcher's awareness of both their own culture and that of participants in their study vital in order to minimize cultural bias throughout the research.

I use psychoanalytically-informed concepts as part of my music therapy approach, and psychoanalysis is, of course a culturally informed model of practice, 'originating in the white, middle class milieu (Littlewood 1992 p. 39). Psychiatrist Bavington (1992) feels that the Western model need not necessarily be discarded in cross-cultural work, but to 'evolve a synthesis that incorporated elements of the existing methods, some of which may in any case be fairly universal, while also recognising basic concepts from the other culture' (Bavington 1992 p. 120). Many music therapists have applied the approach in which they were trained to other countries and communities (Lang and McInerney 2002, Chan 2014, Truasheim 2014, Navarro Wagner 2015). Gadberry's (2014) research found that therapeutic boundaries came up as one of the main cultural differences in cross-cultural music therapy work. Boundaries of time-keeping and privacy had to be negotiated with families as the expectations of both parties were very different. Dhillon-Stevens describes the opportunities for psychological therapists to not only 'have influence at the individual-to-individual level' when working cross-culturally, but also to counter existing societal discrimination (Dhillon-Stevens 2012 p. 642).

2.5 Methodology for the three research strands

I will now describe the distinct methodologies used for each of the three strands of data; the literature review, the research case studies and the parent interviews with IPA analysis.

2.5.1 Literature review methodology

Initial searches showed that there is a huge amount of literature on culture as a discrete subject. Similarly, the related subject of ethnomusicology is a large field of study with much literature and research, and limited relevance to the research topic. For this reason, selected key themes from these subjects that relate to the research questions are introduced. In some models of research methodology, the research

questions would be generated following a literature review that identifies a gap in knowledge. In this study, as described above, the research questions are generated from my own clinical practice.

Culture, intercultural practice and multi-culture are not frequently addressed within music therapy literature, whether in theoretical writing or research. Initial literature searches suggested the following search terms, which were entered into electronic databases:

'music therap*' and 'cultur*'

'music therap*' and 'cross-cultur*'

'music therap*' and 'intercultur*'

'music therap* and 'multi-cultur*'

Electronic databases searched included EBSCOhost, PSYCHinfo, JSTOR, Proquest and Google Scholar. A number of journals were hand-searched: the British Journal of Music Therapy, Nordic Journal of Music Therapy, the Journal of Music Therapy and Music Therapy Perspectives. Following searches using the terms listed above, a 'snow-balling' technique (discussed below) was used to follow up references found in articles identified through the above strategy, in order to identify texts that were not found in the searches. The literature searches took place in 2016, which was the cut off point. Texts relevant to the research that have been published since then are referred to in the Discussion and Conclusions chapter.

The reason for adopting this 'snowballing' strategy rather than, for example, a systematic review was due to the small number of texts on the subject and the number of texts that were not available through databases. A systematic review would involve a pre-determined protocol, replicable by other researchers, with defined search terms and locations (Bettany-Saltikov 2012 p.5). This approach is

better suited to a discrete question for which there is already substantial research literature as opposed to the more exploratory nature of researching intercultural practice within the music therapy literature. The approach adopted for this review allows for flexibility, following up leads and including texts that might emerge and do not fit the original search term but are, nevertheless, relevant, for example a case study for which the focus is not related to culture, but offers valuable commentary on the subject as a secondary issue.

The literature in the review is organized into themes. Following the main part of the review itself, the findings from the review are then discussed in relation to the research questions.

2.5.2 Research case study methodology

Descriptive case studies are commonly employed by music therapists to communicate their work to others: employers, other health professionals or for the purpose of education. Qualitative case study research is a distinct field that uses systematic methodology to analyse individual cases, developed as 'an alternative to the positivistic paradigm and quantitative research' (Smeijsters and Aasgaard 2005 p.444). The positivistic, quantitative models that are considered to be the gold standard of research in healthcare do not acknowledge the individual experiences of individuals, so quantitative researchers 'reached the conclusion that single-case studies are needed to give a *thick description* of complex interactions in a natural context' (Smeijsters and Aasgaard 2005 p. 444, author's emphasis).

Case studies allow for a detailed description of an individual receiving music therapy. Aasgaard's (2002) doctoral research on song writing with children with cancer adopted a design based on five case studies; a number that presents 'no sufficient material for statistical analysis, but is well suited for in-depth interpretative analysis of

meanings and process'. For Aasgaard, the '(qualitative) interpretative methods will capture better different subject's perspectives and will grasp the particular situations and experiences' (Aasgaard 2002 p.54).

Over the course of writing a case study the researcher employs both analysis and interpretation (Smeijsters and Aasgaard 2005 p. 443). Research may contain multiple case studies, but they are considered separately and there is 'no aggregation across cases' (Smeijsters and Aasgaard 2005 p. 443). Furthermore a number of steps must be decided upon and followed in the production of each case study to provide a systematic means of presenting and analyzing data gathered from the clinical work. I propose a number of steps below, adapted from the steps proposed by Smeijsters and Aasgard (2005 p.445-446):

1. The defining of a specific activity or event over a fixed period of time.
2. A research goal based on in-depth understanding and analysis of the case.
3. A qualitative methodology linked to the research goal.
4. Ensuring trustworthiness through checks; repeated analysis, supervision, personal reflection.
5. Triangulation of multiple sources of data: case notes, video material, reports, researcher diary, supervision notes.
6. Narrative account of each case study including thick description and researcher's reflections on the case to help demonstrate the sources of evidence.
7. Examination of the case studies from the point of view of the research questions.

The music therapy sessions took place over a period of 20 weeks, not including school holidays, in the two settings described in chapter four: Greenway school and Allen school. The participants were identified in slightly different ways at the two

schools, as Greenway school had a music therapist working there at the time of the clinical work for the study, and Allen School had never had a music therapist.

At Greenway School, the deputy head identified a list of pupils who would be suitable for referral to music therapy, as was the usual practice in the school. She had a good understanding of the reasons a child might be referred to music therapy as the school had employed a music therapist for three years at this point. She then identified those pupils who would fit the inclusion criterion: that English was not the first language spoken at home. At Allen School, where there was no precedent of music therapy, I met with the Head of Performing Arts and deputy head to describe typical reasons for referral and aims I might work towards with an individual. They were then able to identify suitable children who might benefit from music therapy, and who fitted the inclusion criterion.

In order to answer the main research question, the participants in this study needed to have a cultural background different to my own. There are degrees of cultural difference, and there is no person who has exactly the same cultural background and worldview as my own, even my close family members. Difference in shared language was selected as a fairly blunt, but practical means of identifying difference; while very different cultural and ethnic groups may share a language (Aspinall 2002 p.806), there is less likelihood that there would be no areas of cultural dissimilarity when we used different languages. This criteria was also practical as the schools knew this information about the families already and so were able to apply the inclusion criteria before the families were invited to attend the participant information meetings.

The case studies were drawn together using the music therapist's clinical notes from sessions, the end of therapy report given to the parents and schools at the end of the music therapy sessions, review of video recordings of sessions and from the

researcher diary. The case studies are each set out in a format based on the end of therapy reports. Information is given on the reasons for referral, assessment sessions, the clinical aims for therapy arising from the assessment sessions, the child's progress towards those aims, parents' roles within sessions and recommendations for the future. The case studies then contain further information from the researcher diary on any aspects of the clinical work that would not usually go in the clinical notes, for example a discussion with a parent about listening to music from their home culture, that are of relevance to the research project.

Following completion of the write up of all the case studies, they were discussed in relation to the research questions. Key issues that had arisen during the clinical work were explored by theme.

2.5.3 Parent interviews and Interpretative Phenomenological Analysis methodology

Phenomenology is 'a philosophy that is concerned with the question of how individuals make sense of the world around them and how in particular the philosopher should bracket out preconceptions concerning his or her grasp of the world' (Bryman 2012 p. 697). The challenges of researching a topic so broad and so subjective as culture require an approach that has the flexibility and depth to allow the voices and experiences of individual participants to be heard, yet retains a systematic process that acknowledges and attempts to minimise researcher bias.

Interpretative Phenomenological Analysis (IPA) is a research technique based in phenomenology that seeks to reveal similarities and differences in human experience. It involves drawing data from (usually) semi-structured interviews by transcribing them then putting them through a systematic, qualitative analysis (Smith,

Flowers and Larkin, 2009, p.4). This method is typically employed with research involving a small number of case studies.

> 'The analytic process here begins with the detailed examination of each case, but then cautiously moves to an examination of similarities and differences across the cases, so producing fine-grained accounts of patterns of meaning for participants reflecting on a shared experience' (Smith, Flowers and Larkin 2009 p.38)

Although this technique originated in health psychology, its use has broadened into the human, health and social sciences, and has been adopted by music therapists seeking to explore the richness of lived experience and the patterns amongst groups (Smith, Flowers and Larkin p.5). Kaenampornpan's (2015) music therapy research involved IPA analysis of interviews with family members of the children they had accompanied to music therapy sessions.

2.6 Further considerations for the research

2.6.1 Parent involvement in sessions

The presence of a parent in school-based music therapy sessions is not usual, as at this time of day most parents would be at their place of work, at home caring for other children or elsewhere; in this country parents do not usually attend school with their children. The inclusion of parents in music therapy sessions in this instance was necessitated by the research design; the parents were invited to attend sessions in order to participate in semi-structured interviews following the conclusion of music therapy sessions. Parental presence in sessions was a divergence from the naturalistic approach described earlier, however it was necessary to include this step in order to obtain the parents' valuable perspectives on the music therapy sessions, as their children were non-verbal or had limited speech. There is an established precedent for music therapists working with parents and families in other settings (Oldfield, Flower and Hesketh 2008, Jacobsen 2009).

2.6.2 Amelioration of Researcher bias

In order to conduct valid research my own practice, I took steps to minimize any conflict between my two roles as practitioner and researcher. The first of these was the use of clinical supervision, which was used both to help me reflect on my clinical work as is usual in music therapy practice, but also to address any concerns I had that my role as researcher was affecting my clinical decisions. I also kept a researcher diary. This was a place to record my observations or reflections connected to the music therapy sessions that would not go in the clinical notes.

2.6.3 Ethical considerations

Ethical approval was sought and granted by Anglia Ruskin University Research degrees ethics board. This process included approval of the process by which informed consent was sought from the participants via appropriately worded participant information forms and consent forms for the children and their parents, and approval from the schools hosting the research. Copies of the participant information forms and consent forms are included in Appendices 1-4.

2.7 Conclusion

This chapter has outlined contrasting research paradigms, the music therapy research context and considerations for multicultural research.

The rationale for the adopted methodology for this research project has been given, and the detailed methodologies for each of the three strands of data that were used to provide answers to the research questions. The presence of parents in sessions and measures to ameliorate researcher bias were considered along with the procedures for obtaining ethical approval.

Chapter three

Literature Review

3.1 Introduction to literature review

This chapter presents literature connected with music therapy practice linked to culture, both through music therapy literature and also that of related disciplines. The methodology for the literature review is outlined as well as the system devised for managing the literature. Some key ideas from related fields; ethnomusicology, education, psychotherapy and the wider arts therapies; are presented after the main section of the chapter which contains the literature on music therapy and culture. The results of the review are then summarized and related to the research questions.

3.2 Summary of literature review methodology and technique for organizing literature

Within music therapy literature there is a limited amount of material referring to culture and intercultural practice. This literature mainly comprises music therapists' own theoretical and practical perspectives on cultural issues on music therapy. There is very little music therapy research into the subject of culture within music therapy, and what there is draws mainly upon music therapists for its data, as opposed to people from minority cultural backgrounds.

The related subject of ethnomusicology, which looks at culture and music as a whole is an enormous field, so some key ideas that music therapists have found useful in their work have been considered. Similarly the subject of culture in itself is vast. In order to reduce the scale of the possible literature I have confined the search to what music therapists have written about culture, and music therapy research in this area.

As described in the Methodology chapter, literature searches of books, journal articles and other sources, e.g.newspapers took place using the terms ‘music therap*’ AND ‘cultur*’, ‘cross-cultur*’, ‘intercultur*’or ‘multi-cultur*’. Electronic databases were searched for all English language literature containing the above terms. A number of journals were hand-searched, including the British Journal of Music Therapy, the Nordic Journal of Music Therapy, the Journal of Music Therapy and Music Therapy Perspectives. Following these searches, a ‘snow-balling’ technique was used of following up references found in articles identified through the above strategy, in order to identify texts that had not emerged in the searches. The literature searches took place in 2016, which was the cut off point. Texts relevant to the research that have been published since then are discussed in the Discussion and Conclusions chapter.

Techniques developed for organizing literature

My research experience prior to commencing this piece of research involved Master’s level research. For this reason it was necessary to devise new strategies and techniques for managing the significantly larger scale literature review required for this study: both the number of texts involved and over a longer period of time. PhD literature searches are much more comprehensive than those at Masters level and include international literature (confined to English language texts in this instance). Also library restrictions meant that not all the texts would be available to the researcher at once. The techniques will be briefly described here in case they are useful to other researchers.

Each identified text was placed in a table. The columns contained an assigned number, the full reference, and a sub-topic, e.g. within the music therapy and culture table a text was given a code that identified it as related to research, clinical practice etc. Quotes from the texts illustrating the points from the text relating to the research

questions were included, with page numbers, and following this a letter was assigned to each point. For example, text 1 included points a, b and c relating to a) music therapy and culture more broadly, b) music therapy in the home, and c) personal variation within cultural groups. An example of this table may be found in Appendix 5. Once an exhaustive search had been conducted across a period of two years, a second table was made to assist in the writing of the review. The sub topics were divided into smaller topics and next to them was the codes for the references were placed. So, in the section of the literature considering how the use of music in different cultures can affect music therapy practice, the paragraph about performance in music therapy contained two references; '7' and '21b'. This process meant that texts could be collated over a long period of time, full referencing information was kept, the review could be planned and written based on the themes that emerged through the literature search.

The literature in the review below is organized by theme. Following the main part of the review, links are drawn between the research questions and the main findings from the literature review. Finally, the chapter is summarized.

3.3 Music Therapy and Culture

3.3.1 Introduction

The subject of the impact of culture on music therapy practice is addressed to a small extent in music therapy literature. Several authors have voiced a plea for more research into this area (Bradt 1997 p.42, Forrest 2014 p.15). Existing research has, in the main, involved examining music therapists' own perspectives on the relevance of culture to various areas of practice; clinical work, training and supervision. Voices of patients are rarely heard directly, on the rare occasions they are, it is usually through the music therapists interpretation in case studies or vignettes.

Authors and researchers from Australia and the United States seem to be more prominent in the literature. In Australia, Jones, Baker and Day (2004) and Hunt (2005) both worked with teenage refugees. Forrest (2014) wrote about considerations when working in the family home; sharing their culture, songs and language, and coming into their personal family culture. Sham (2014), a Chinese music therapist working in Australia considered that having a shared background with a client led to greater cultural empathy and increased the effectiveness of the therapy. In the United States, Moreno (1988) was one of the first to write about multicultural music therapy. He felt that music therapists should have knowledge of the music of a range of cultures to facilitate cross-cultural work. Hadley (2014) has written extensively about music therapy and race, and the need for music therapists to acknowledge and understand their place in white majority culture. Kenny (2014) is a U.S. music therapist with a First Nations cultural background, and finds the shared background helps her in her work with those communities. Schwantes' (2011) doctoral research examined music therapy with Mexican migrant farmworkers. Authors who have a Community Music Therapy orientation are also well-represented in the literature about music therapy and culture (Pavlicevic 1997, Stige 2002, Zharinova-Sanderson 2004, Navarro Wagner 2015).

In spite of the lack of literature, I believe that culture in music therapy practice is an important and complex subject, and one that should be examined as it influences so many different elements of music therapy work. Music therapists' own attitudes must be considered alongside their patients, as all people are influenced by culture. Through purposive sampling of music therapy educators who had worked in more than two countries, Wheeler and Baker (2010) obtained qualitative data on attitudes and worldviews of the participants. One of the findings they considered most striking was 'how many different things seem to have influenced people's worldviews – as varied as childhood musical experiences, societal and governmental policies, and

traumas' (Wheeler and Baker 2010 p.223). They felt this was 'part of the reason that this topic is so important and also so difficult to deal with' (Wheeler and Baker 2010 p.224).

Another reason research is needed in this area is that throughout the twentieth and twenty-first centuries, movement of people around the world has increased. In 2014 the Australian Journal of Music Therapy published a special issue with contributions on the subject of music therapy and culture. In her editorial, Shoemark wrote 'The growth in immigration patterns around the globe means that inevitably we will connect with people from many cultures in our practice, research and development of knowledge' (Shoemark 2014 p.1). Most people in the Western world now live in multicultural societies and whether we choose to live and work abroad or remain within our home community, we will encounter music therapy clients with different cultural backgrounds to ourselves, with the varied implications this contains for our music therapy practice.

3.3.2 The meeting of cultures in music therapy sessions: the culture of the client, the culture of the therapist

In a music therapy session, two individuals come together. They carry with them their unique experiences and backgrounds, which influence how they experience the world around them, but also enter into a dynamic process of forming a new relationship through making music together. In musical improvisation, Pavlicevic considered that the therapist and client are negotiating their own culture together (Pavlicevic 1997 p. 56). Furthermore, the music therapists interviewed by Swinburne (2013) in her Master's research felt that in improvisation they were able to musically 'meet' their clients despite any other difficulties the therapists felt were due to cultural difference (Swinburne 2013 p. 61). In musical improvisation, a new way of being together was created, one that seemed less affected by cultural difference.

One factor that overcomes cultural barriers is the awareness of our common humanity, and the emotions and struggles we all share. In coming together in music therapy, forming relationships and making music together, music therapists observed that despite differences between their clients, these broad commonalities came to the fore. Hunt observed, when running music therapy groups to help newly arrived refugees integrate, that these teens, like all others, had issues of identity and peer acceptance (Hunt 2005). Orth and Verburght ran a music therapy group with traumatised refuges in Holland. They felt that some universal emotions were revealed in this group; fear, longing, anger, pride and joy (Orth and Verburght 1998 p.83). Yehuda's research interviewing music therapists and musicians observed that when people recognise the feelings expressed in a piece of music from a different culture as the same as their own, they can then feel a particular attachment to this style of music (Yehuda 2002 p.12).

3.3.3 Using the client's music in music therapy sessions

Several music therapists who work with clients from different cultural backgrounds have written about the use of music of the client's cultural background in sessions. This appears to be a complex issue with many potential benefits and pitfalls. In their work in post-war Bosnia, in an atmosphere at times of suspicion and ethnic tension, Lang and McInerney's clients brought their 'own' music to sessions (Lang and McInerney 2002). Orth and Verburght, when working with refugees, felt that sharing their 'own' music helps keep people in touch with their own culture and identity (Orth and Verburght 1998, Orth 2005 p.6). Amir points out, however, that while some clients want to remember their home culture, others prefer to 'fit in' and learn the music of their adopted culture; personal variation must be taken into consideration (Amir 2004).

Different questions are raised, however, when the music therapist plays the music of the client's culture, rather than the client themself. Moreno felt that in multicultural work it was beneficial to learn 'a few words' in the musical language of the client (Moreno 1988). Several music therapists have warned about the risk of losing authenticity in the music, when trying to reproduce music from another culture. Bradt raises the question, how much can a music therapist adapt without losing their authenticity (Bradt 1997 p.139)? Pavlicevic gave an example of this; she described working with a group of teenagers in South Africa. She tried to introduce a Xhosa dance, and they 'fell about laughing' as a response to her inability to capture the authentic nature of the music, or in her words, her attempt to 'import false culture' (Pavlicevic 1997 p.56). When working with the elderly Chinese community in Australia, Ip-Winfield, Wen and Yuen sometimes used recordings rather than attempt to reproduce clients' favourite songs, in order to maintain musical authenticity (Ip-Winfield, Wen and Yuen 2014 p. 130).

3.3.4 Music therapists with multi-cultural backgrounds

Cross-cultural work is occasionally facilitated by a music therapist from a (multi-) cultural background similar to their client. Susan Hadley's book, *Experiencing Race as a Music Therapist: personal narratives* (Hadley 2014), comprises a fascinating series of interviews with music therapists in which they address the subjects of race and culture within their work and lives. Carolyn Kenny, who worked with First Nations Americans and shares this background herself, considered having a shared native language as a huge part of her work (Kenny in Hadley 2014). Aaron Lightstone, a Jewish music therapist, felt having a shared heritage with his elderly Jewish patients increased the benefits of the therapy; it allowed for a deeper relationship to develop than with non-Jewish therapists; 'they [the non-Jewish therapists] were familiar enough with the music to facilitate that group in a completely competent way. However, I think that by just having the shared culture, I could go a

bit further and a bit deeper, with the Jewish cultural piece, when running a group like that' (Lightstone in Hadley 2014 p. 35). The interviews in this book are striking because of the authors' willingness to speak very openly and in depth about their cultural background, including their biases and limitations. Other authors will go on to show such self-examination is vital in effective inter-cultural music therapy work.

3.3.5 Community Music Therapy approach

Community Music Therapy is an approach that amongst other considerations emphasises the cultural and community context of the participant in music therapy, arguably more than other music therapy approaches.

> 'In its opposition to many of the underlying tenets of psychotherapeutic and medical approaches, Community Music Therapy represents a different way of thinking about music therapy practice. Furthermore, its emphasis on community, culture and context aligns music therapy more closely with the principles of Community Music' (O'Grady and McFerran 2007 p. 14).

Rather than using descriptions based in healthcare and the medical model, Stige and Aaro list seven 'qualities' used by practitioners of Community Music Therapy which they believe characterize the approach (using the acronym 'PREPARE); 'Participatory, Resource-oriented, Ecological, Performative, Activist, Reflective, Ethics-driven' (Stige and Aaro 2012 p.18). The term 'ecological' is used to represent the reciprocal relationships between individuals, groups and their environment (Stige and Aaro 2012 p.22).

Following a period of music therapy volunteer work in Uganda, Navarro Wagner found these Community Music Therapy qualities helpful in reframing her work, especially in bringing meaning to the more challenging aspects of her experiences. In Uganda, she struggled particularly with maintaining boundaries of time and place as she understood them but realised, 'these difficulties clearly came from my personal assumptions, worldview and music therapy background: my personal frame. In Gulu [town in northern Uganda], my assumptions were totally out of context. They had no

skeleton to hold onto and they felt meaningless' (Navarro Wagner 2015 p.5). Using Community Music Therapy qualities, especially the 'ecological' quality, which requires recognition of 'the social nature of the individual's sense of self' (Navarro Wagner p. 10), she was able to re-frame her music therapy activities within the local context:

> When we position ourselves differently, the view of what we look at changes. And healing can only appear when changes are allowed to emerge and allowed to be ex-pressed within a frame of reference (Navarro Wagner 2015 p. 15)

For Navarro Wagner, Community Music Therapy offered a means of viewing her music therapy practice through the lens of the local context, and thereby re-discovering meaning in her experiences.

Stige (2002) speaks of the 'fifth force' in music therapy; culture-centeredness, or sensitivity to culture and context, and presses his goal for all music therapists to integrate cultural perspectives into their thinking (Stige 2002 p. 5). He notes that music therapy itself is a culture just as music therapists themselves are part of, and subject to, the cultural influences around them (p. 321).

3.3.6 Music within different cultures

'Ethnomusicology is the study of music in its social and cultural contexts. Ethnomusicologists examine music as a social process in order to understand not only what music is but what it means to its practitioners and audiences' (The Society for Ethnomusicology 2020). It is 'the study of why, and how, humans are musical' (Rice 2014 p. 9). From my previous clinical experience on which the research questions were based, I felt that cultural factors influence music therapy practice in many ways, both musical and non-musical. Music therapy practice is not based in music alone, but depending on the therapist's theoretical orientation has roots in other areas as well, for example psychoanalysis, humanistic approaches. I therefore

wish to focus on the music therapy literature that is more likely to encompass all of these areas and therefore offer fuller answers to the research questions.

The sub-questions explore function and cultural identity in music. These are complex areas and ethnomusicologists have considered these aspects of music. Ethnomusicologist Blacking described musical traditions as 'probably the most esoteric of all cultural products' (Blacking 1987 p. 129 in Brown 2002), hinting at the difficulty in ascribing concrete meaning to music.

Bright's (1993) research into culturally informed perceptions of music involved playing excerpts of Asian music to European people. An Asian audience had previously agreed on the predominant emotion communicated by the music. Her findings were that the European audience experienced the emotions differently to the Asian audience, both in levels of intensity of the emotion experienced and the type of emotion (Bright 1993 p. 193-207). This becomes relevant in music therapy practice when one considers that the music therapist will interpret the client's music (and vice versa) according to their own cultural understanding. Bradt gives the example of mis-diagnosis due to cultural difference when working with a Hispanic client: The Western music therapist interpreted the client's loud, fast playing as a self-control issue. In fact, Bradt reflected she should have considered 'the unique way in which Hispanics express their distress… which are characterised by heart palpitations, vehement gestures, a rise of their voice… These gestures are often misinterpreted and mistakenly thought to represent various diagnostic conditions' (Bradt 1997 p. 142). This observation that different cultural backgrounds can be a source for aesthetic bias (Yehuda 2002 p.3, Orth 2005 p. 3), leads to the question posed by Pavlicevic (1997 p.56); do we really share meaning with clients in music therapy sessions?

The role of music in music therapy sessions may be affected by the role music plays within a particular culture, and awareness of these cultural roles has shaped the direction of some music therapists' clinical work. Zharinova-Sanderson worked with refugees in Berlin, and wrote about aspects of her work that were appropriate to the musical cultural life of her patients. Although performance is not usually a feature of some music therapy approaches, she gave an example of work with a Kurdish man in which performance became a key part of their sessions. She commented that in some cultures music is inseparable from performance and the therapist should make space for this (Zharinova-Sanderson 2004 p. 243). This client was also unwilling, initially, to see her alone for sessions; something that was not culturally appropriate for him as she was a young woman unrelated to him; but the presence of a trusted translator allowed them to work together, until they reached a point where he did not mind them being alone, ' "We are not alone any more", he said, "the music is there with us" ' (Zharinova-Sanderson 2004 p. 239).

Hunt (2005) used music therapy to help newly arrived young refugees in Australia integrate into their new society. They took ownership of the therapy process and performance would sometimes be involved. She noted that while their status as refugees gave them some specific needs, they also had the same issues of identity formation and peer acceptance common to all teenagers (Hunt 2005). Orth noted, however, that the perspective of the use of music was slightly different for refugees from central African countries to those from Western countries:

> 'For example I found that mid-African refugees sing, dance, and improvise considerably easier than refugees from Western cultures. In mid-African countries music seems to be an integral part of life and it is more important as an expression of emotions and feelings than as an artistic form' (Orth 2005 p.4).

The musical experiences of mid-African people in comparison to those from other parts of the world was noted by a piece of research from UK charity Music as

Therapy International (Quin and Rowland 2016). They analysed the musical skills of local staff from a number of locations around world (Rwanda, Occupied Palestinian Territories, Romania) who had been involved in their skill-sharing projects, and found that the Rwandan staff scored significantly higher on competencies involving the use of musical skills and instruments (Quin and Rowland 2016 p. 121). As none of the local staff was required to have undertaken any specialist musical training prior to their involvement in the skill-sharing project, the authors reflected that the high scores of the Rwandan staff could relate to the 'strong tradition of communal music-making within Rwandan society' (Quin and Rowland 2016 p. 126).

Cultural factors can affect other aspects of music-making. Jones, Baker and Day (2004) noted the importance of understanding culturally linked uses of instruments and musical techniques in music therapy work. This knowledge was crucial when working with young Sudanese refugees; the Luer tribe of Sudan uses shakers to contact the spirit world, and therefore given this association these types of instruments should be used with care in music therapy sessions. They also found that with this group of young people, musical techniques involving close imitation and synchrony were actually detrimental to the relationship. Playing very closely along with another was often experienced not as a positive, supportive technique, but actually that it was too claustrophobic. The music therapists adapted these techniques to have one person playing more sparsely; this felt more comfortable for the young people (Jones, Baker and Day 2004 p. 94).

Many music therapists commented on how music was able to transcend cultural barriers (Moreno 1988 p. 17), gender, nationality, age (Chan 2014 p.96); within a short space of time music could bring a diverse group of people together (Orth 2005 p. 5). A number of music therapists felt that it was not the music that created or contained any kind of barrier, it was other cultural issues that affected music therapy

practice. Examples given by music therapists of the potential barriers in play included negative attitudes to difference, gender, race, power politics (Swinburne 2013 p.62); cultural differences in attitudes to sickness (Orth 2005 p. 5); a therapist from a Western 'individualistic' culture and client from a group culture and the ensuing differences in understanding, and the non-directive, 'democratic' approach of a Western therapist might come across as incompetent to clients from some cultural backgrounds (Bradt 1997 p. 138).

3.3.7 Additional areas of music therapy practice

Valentino identified four factors essential to effective cross-cultural work: 'awareness of one's cultural context, knowledge of cultural factors, the use of cognitive and affective empathy, and the ability to effectively communicate empathy' (Valentino 2006 p. 110). Several authors commented on empathy in particular as being a clinical skill that was affected by cultural difference between music therapist and client.

Describing empathy as the therapist's ability to 'perceive the client's world-view or feelings accurately and completely', Chan stated, 'different cultural backgrounds, and lack of awareness of the client's unique cultural background may create barriers to empathic understanding' and that 'cultural empathy… requires the therapist to acknowledge his/her own cultural identity and cultural biases' (Chan 2014 p. 98). Tsz Ying Sham, a Chinese music therapist working in Australia, felt that her background influenced the effectiveness of her work when working with clients from Hong Kong:

> 'When I work with people from Hong Kong, I also understand the background story, so what their stressors are for each issue. We share an understanding, so it is easy to "feel" with them, because they don't need to "spell it out". But if they are from a different culture. I don't always understand the background to the stressors of the issue' (Thomas and Tsz Ying Sham 2014 p. 86)

Chan also gave an example from her own clinical work of a cultural empathy barrier; describing work with an elderly Austrian immigrant in Australia, Chan noted that 'the

interpretation of help-seeking and coping are different in various cultures'. While Chan from her music therapist's point of view felt it appropriate for her client to seek help, her client 'perceived this behaviour as losing dignity and self-reliance… influenced by her experience as an Austrian immigrant' (Chan 2014 p.99).

Gadberry used thematic analysis of journals of a music therapist who did some short-term work overseas to explore cross-cultural issues. Therapeutic boundaries were highlighted as one of the main cultural differences impacting the music therapist's work. The music therapist found her boundaries of timekeeping and limiting interruptions to the sessions were very different to the expectations of the families and found herself negotiating a rule with them to maintain the necessary therapeutic space (Gadberry 2014 p. 73-74)

3.3.8 Language and 'mother tongue'

Gadberry's research also focused on the presence of a language barrier within music therapy sessions. The music therapist involved in this research was unable to communicate verbally with the children as they had no shared language, causing her to feel 'frustrated, inadequate, disconnected' and required the staff to translate for her. She found that she was able to use non-verbal means, however, to ameliorate this issue; 'The children's energy, the children's expression – non verbal, gestural, how the children communicated through music – what instrument/voice/silence… all these components assisted me in understanding who they are and what they need' (Gadberry 2014 p. 75).

Music therapists are equipped to work with non-verbal communications, just as improvisation in music therapy provides clients with a non-verbal means of expressing themselves. Orth felt that while a language gap '[makes] working together more complicated and causes limitations to the way clients can make themselves

verbally understood', it also created a kind of safety in that the client could freely express their thoughts and feelings in musical improvisation in their mother tongue, in the knowledge that the therapist does not understand them (Orth 2005 p.4). Bradt noted that clients who are communicating with their therapist in a language that is not their own are 'distanced from themselves' in their expression, and the therapist must be aware of this (Bradt 1997 p. 143).

In their music therapy work with the aged Chinese community in Melbourne, Ip-Winfield, Wen and Yuen adopted a number of strategies to support their culturally sensitive approach. One of these was that all the staff in the project including the two music therapists were all bilingual and bi-cultural (Ip-Winfield, Wen and Yuen 2014 p.129). It should be noted that Chinese-speaking music therapists planned and delivered this intervention with the aged Chinese community; bilingual therapists working with a specific client group is something of a rarity in the literature and, most likely, in practice.

3.3.9 Working in the home

Music therapists work in a wide variety of settings; education, healthcare and social/community settings. They may also work in clients' homes. Forrest observes that such music therapists, upon entering the family home, are 'immediately immersed in the culture and dynamics of the family' (Forrest 2014 p.15). Furthermore 'each family has its own musical culture… Some families bring songs in their own language or from their own culture to music therapy… and [invite] the music therapist to share in the family's personal culture (Forrest 2014 p.16). Bradt emphasises the need for music therapists to gain an understanding of the role for music in certain cultural practices, for example around healing practices and commemoration of the dead, when working with families (Bradt 1997 p.139).

3.3.10 Music therapists' own backgrounds

Music therapy training courses are usually degree (undergraduate, or in the UK and parts of Europe, postgraduate) level and require a high level of musicianship. This musical training will most likely be based on years of childhood musical training outside school, and initially funded by the family. These factors point towards music therapists coming from families with an intermediate or higher level of socio-economic resources. While there is not, at present, published data on this subject, my attendance at the 2016 and 2014 British Association for Music Therapy conferences, at which approximately one third and one half of the profession were represented respectively, showed a profession almost entirely represented by white faces with very few exceptions. This picture does not, however, represent the clients with whom music therapists work.

Thomas and Sham explored the experience of a 'foreign' music therapist (Sham) working in Australia. Sham had to go through a process of learning a new culture; 'all the things you are not aware of if you are living in your own culture' (Thomas and Sham 2014 p. 83). She felt that as she became aware of the cultural differences around her she made fewer assumptions in her clinical work (p.85). These assumptions are present on both the part of the therapist and the client, but need to be brought to consciousness through experience as 'sometimes "we don't know what we don't know" when building therapeutic relationships with patients from a different culture' (Thomas and Sham 2014 p. 90). And when a therapist is unaware of cultural difference in sessions? Sham commented, 'patients from other cultures *know* that they are from another culture, so even though clinicians may not approach them in the most comfortable way, I think the patients are the ones that accommodate the cultural gap' (Thomas and Sham 2014 p.88).

Hadley's book addressed this issue from an international perspective, indicating that the picture is similar in many countries; music therapists are more likely to come from the majority culture and a privileged one at that. Members of the majority culture, including many music therapists, 'can get away with not dealing with issues of race if we don't want to (Hadley 2014 p.209). She continued;

> 'I believe that in music therapy, as well as in our personal lives, we must begin by breaking down white identity, because without truly having an understanding of what that is and the impact it has on how we view ourselves and others, there is little hope for a true exchange across racial identities and cultures' (Hadley 2014 p. 222).

3.3.11 Music therapy training

In this time of increasing diversity, some authors felt music therapy training programs should address cultural issues to some, or a greater extent (Toppozada 1995 p.72, Hadley 2014). In her discussion on ethics and multicultural counseling, Bradt commented; 'making music therapists aware of potential ethical issues when working with culturally different clients should find its foundation in the music therapy training programs [although] becoming a culturally skilled music therapist is an ongoing process that never ends' (Bradt 1997 p.141). Pavlicevic felt that music therapy training should involve elements of ethnomusicology, with students experiencing music from various cultures and becoming acquainted with the associated differences in 'musical energy' (Pavlicevic 1997 p. 56)

Wheeler and Baker researched the influences of music therapists' worldviews on their practice. One of their findings was that music therapists felt their training should offer a space for exploring students' belief systems. Also, some of the music therapists they surveyed felt that supervision could be complicated by a difference in cultural backgrounds between the dyad (Wheeler and Baker 2010 p. 216).

Toppozada (1995) conducted a survey of US music therapists examining their professional knowledge of working with clients from different cultural and ethnic backgrounds to themselves. The respondents strongly indicated that a client's cultural background should be taken into consideration (p.78). While the respondents generally felt training courses should involve more cultural awareness, they suggested a variety of approaches including those based in musical techniques and counseling and therapy theory, but many conceded that training courses were already overloaded. The author suggested an approach that involved making training courses more culturally sensitive as a whole might be a more practical approach (p.81). Some music therapists received their multicultural training from their clinical placements or work settings, or personal experience of travelling and being exposed to different cultures (p.82).

Those who had not had training felt there was something lacking in their education, and highlighted special education as an area in need of a culturally sensitive approach; 'In special education, an understanding of various cultures would be especially helpful when working with parents' (p82), leading Toppozada to comment further that when working with pupils with English as a second language, these individuals 'may face the double barrier of unfamiliar information coupled with unfamiliar music' (p.84). Ultimately, Toppozada concluded that multicultural training must be built on a firm philosophical foundation (p.85), and called for further research into this area to 'contribute to the teaching of multicultural music, culturally sensitive teaching techniques, and above all, intercultural tolerance and acceptance (p.86).

3.3.12 Music therapy and culture research

As stated earlier, there is a limited amount of research into music therapy and culture. What exists utilizes music therapists as participants in studies; the voices of patients are rarely heard. The research methodologies adopted are nearly all

qualitative in nature. One notable exception to this is Schwantes' doctoral research into music therapy's effects on Mexican migrant farmworkers' levels of depression, anxiety and social isolation. This mixed methods randomized control trial used participatory action research (PAR), and Schwantes highlighted the benefits of PAR in recognizing the subjects as researchers, building trust and mutual respect within the research process, and recognizing the subjects are part of a distinct community that the researcher might not understand (Schwantes 2011).

Another research study that involved client voices was Truasheim's work as a music therapy student with Torres Strait Island people. She drew on Saggers et al's definition of cultural safety in examining music therapy practice, '[cultural safety is] the effective delivery of services to people from another culture, as determined by individuals and groups from that culture' (Saggers et al., 2011. p.18 in Truasheim 2014 p.136). Qualitative questionnaires were administered to clients to evaluate the impact of a music therapy pilot project, and responses underwent thematic analysis. Truasheim explained that 'when clients are able to evaluate the effectiveness of services for them through their own cultural lens' (Truasheim 2014 p.142), cultural safety can exist. She felt that a key factor in providing cultural safety involved partnership with both clients and communities; 'Partnering with clients ensures that there can be an open dialogue about the cultural protocols the client values and discussion of any offence caused. This partnership occurs through client-led goal setting, an understanding of the client's first language and literacy skills, and regular requests for honest feedback (p.144)

Thomas and Sham, a music therapist supervisor and supervisee, elected to explore cultural difference in their work through recorded conversations between the two of them, using a duo-ethnographical approach (Thomas and Sham, 2014 p. 81). Thomas is Australian and Sham is Chinese and at the time of the research they

worked together in a hospital setting. Their duo-ethnographical approach gave them the means to explore their experiences of culture in their work, drawing out themes from their conversations and create insights (Thomas and Sham 2014 p. 90)

3.4 Culture in wider psychotherapies literature

The psychotherapy, arts therapies and counseling professions have explored the issue of intercultural practice in research and theory. Music therapists can learn much from their body of knowledge.

3.4.1 Disparity of access to therapies for minority ethnic groups

Minority ethnic groups are marginalized by healthcare systems; both in their access to healthcare, and in spaces designed to give healthcare users a voice in shaping services (Freitas and Martin 2015 p. 31). Causal factors include 'inequalities in socio-economic status, communication skills and self confidence [which] may lead some – usually those already silenced – to silence themselves' (Freitas and Martin 2015 p. 32). Other minority groups find themselves disproportionately pathologised by mental health models that are 'culturally constructed and therefore culturally specific' (Dhillon-Stevens 2012 p.55). Dhillon quotes UK based mental health statistics that 'of 31.8 per cent of service users receiving care on inpatient units detained involuntarily, 53.8 per cent were black' (p. 55). Fernando identifies people from minority cultures as being failed by mental health models:

> 'non-Western cultures that are alien to psychiatry are themselves seen as pathological. In this way 'culture' becomes the 'problem' that accounts for the abnormal behaviour of the client. The perception of a minority group as 'having' a problem insidiously turns to perceiving them as being the problem' (Fernando quoted in Kareem and Littlewood 1992 p. 12).

The literature from the psychological therapies indicates that people from minority ethnic backgrounds find themselves misunderstood by models that work against their

cultural strengths, are not able to access healthcare and are not able to influence systems through the established mechanisms of change.

3.4.2 Challenges for psychotherapists in talking about difference

Psychological therapists can find it deeply uncomfortable talking about racial, ethnic, or cultural difference, and therefore may struggle to competently address the subject (Dhillon-Stevens 2012 p.57). One of the reasons for this is that on this subject personal feelings are closely bound up with the professional (p. 55). Furthermore, where the therapist is from a white majority culture that has in the past subjugated the client's ethnic group, deep-seated barriers may exist; 'can you really engage in authentic dialogue with someone who represents deep emotional hurt in your history?' (p. 58).

Ryde (2009) commented on the challenges for white people in understanding their place in an historically dominant culture:

> 'I came eventually to understand 'white' to mean the European diaspora which now dominates global culture in its economic, political, cultural and social arrangements. I also discovered that, however much we would like to deny it, we carry with us in all our interactions with those who are not white (as well as those who are) a legacy of history and this includes both slavery and colonization. In the context of our worldwide domination it is only too easy to see ourselves as just 'normal', particularly if that normality affords us an easy, privileged position in the global society (Ryde 2009 p. 33).

This journey of understanding is one that Hadley implored music therapists take, in order to more effectively achieve exchange across racial and cultural barriers, as described in section 3.3.10 above.

3.4.3 Recommendations for improving intercultural practice from psychotherapy research

Dhillon-Stevens (2012) outlines some key principles for good practice in intercultural psychotherapy, using the concept of Anti-Opressive Practice (AOP). Below are some of these principles that relate most closely to music therapy practice:

- Awareness of stereotypes, and how these may hinder patients obtaining the support they need.
- Non-verbal behaviours such as eye contact, gesture, body distance, touch and tone of voice, and how they are interpreted through a cultural lens
- Definitions of identity, including (often Western) individualistic versus collective or group cultures.
- Personal versus professional boundaries, which may vary across cultural groups, including ideas about self-disclosure.
- Concept of empathy, the manner of demonstration and communication of which is culturally dependent, and becomes more difficult where interpreters are used
- Working alliance, and developing how and when to raise issues of difference in therapy.
- Making mistakes: expecting to do this, and reflecting on these and the difficult feelings that arise in order to learn from such mistakes.

  (adapted from Dhillon-Stevens 2012 pp.647-648)

3.4.4 Psychotherapy, disability and culture

Parritt (2012) highlights the ongoing disputes about global definitions of disability, caused in part by the notion that disability is a social creation (Parritt 2012 p. 30). Around the world, societies have varying ideas about disability; for some, ‘disability has often been seen as punishment or possession’ (p. 31) and cultural or ethnic

groups may have particular views on the expected life roles of disabled people. He gives the example of a young disabled person's family members who expect this person to remain fully dependent on the family, not working or having sexual relationships (p.32).

Disabled people are a minority in the UK, and therefore psychotherapists should consider disability as a culture in itself (p. 33). Much as the music therapy and psychotherapy literature encourages the therapist to examine their own beliefs and prejudices around ethnic and racial difference, therapists should try to 'understand the client's belief system as well as their own in relation to disability, impairment and chronic illness and their role as counsellor or therapist (p. 32).

3.4.5 Other arts therapists' perspectives on intercultural practice

The British Association for Dramatherapists (BADTh) has surveyed the cultural and social profile of its membership and found it to be slightly more culturally diverse than the national average, with some cultural groups underrepresented: 'Asian, Islamic or Hindu therapists' (Doktor 2016 p. 94). While there has not been a similar survey in the UK music therapy profession examining both the cultural and social background of therapists, I suspect from my attendance at conferences at which up to fifty per cent of the membership were present, that the music therapy profession is less diverse than dramatherapy. From her research into the dramatherapy profession and practice Doktor has developed good practice guidelines for intercultural work (Doktor 2016 p. 106) that have subsequently been disseminated amongst the profession via the BADTh website. These guidelines state the importance of the therapist's awareness of their values and attitudes and awareness of identity, especially white identity (p. 107).

3.5 Culture and ethnicity in education

Frederickson and Cline observed almost twenty years ago that, 'Every aspect of society that affects the treatment of disabilities and learning difficulties has changed radically and continues to evolve' (Frederickson and Cline, 2002 p.4), in response to the increasingly diverse UK population. Huss-Keeler (1997) noted that when Punjabi speaking Pakistani parents expressed interest in their children's learning, their interest was misinterpreted by teachers because its manner of expression was different from white parents' engagement in the school. This finding matches that of Rehal (1989) whose research highlighted poor school communication with Punjabi speaking parents in one London borough. Parents from minority ethnic groupings are often seen as 'hard to reach'; Crozier and Davies suggest that parental involvement policies need to recognise ethnic diversity accurately to be successful (Crozier and Davies 2007). Parental engagement is made more possible if efforts are made to understand the local community and the relationship is seen to be reciprocal (Harris et al. 2007).

Children and their families can become doubly isolated as 'the interplay of race, culture, religion and disability has been largely ignored by many service providers' (Broomfield 2004, p.9). Broomfield's study saw parents from ethnic minority groups reporting higher levels of unmet needs due to an inaccessibility of services and information, so that 'services not only fail to meet needs, but also serve to re-inforce social inequality' (Broomfield 2004, p.45).

3.6 Relating findings from literature review to research questions

The research questions are set out below. I will now discuss the findings from the literature review in relation to these questions.

Main research question

- What factors does a music therapist need to consider when working with a child from a cultural background other than her own?

Sub-questions

- How do culturally informed perceptions about the function of music affect music therapy work?
- Music has links with cultural identity: How does this relate to music therapy practice?

3.6.1 Main research question

What factors does a music therapist need to consider when working with a child from a cultural background other than her own?

The main research question relates to how a music therapist might adjust their thinking and approach when working with someone who has a different background to them. Theorists and researchers in this field have suggested a wide range of factors to consider, both in music therapy clinical work and for further training and research to support future practice.

A meeting of cultures

Many of the authors and researchers cited in this review draw attention to the fact that both therapist and client bring their own cultural heritage to the music therapy relationship. The two most significant points about this are firstly that it is important to acknowledge the complexity of cultural identity, relating as it does to ethnicity, religion, gender, sexuality, conscious and unconscious beliefs, assumptions and behaviours, and this is then multiplied by two for the two people in the room. Secondly, that the therapist brings their cultural background too and must be aware of this and how it relates to the client they are working with or they may be held

hostage by their unconscious processes related to cultural identity and struggle to develop a meaningful relationship.

A music therapist working with a person from a different background to themselves needs to acknowledge the complexities of this difference, and also that they may need to examine the impact this has on them as a person.

Non-diverse profession

Researchers from several countries have noted that music therapists usually occupy the more privileged class in their society, coming from (often white) wealthy backgrounds. Music therapists are rarely from minority ethnic communities. This is significant because research has shown that people from majority cultures are less effective at noticing cultural mis-matches and issues. People from ethnic minorities have spent a significant proportion of their lives experiencing being different to the majority and adjusting to fit accordingly. This adjustment may take place in music therapy sessions, without the music therapist realising the patient is smoothing the way for the therapist.

Furthermore, music therapists from white privileged backgrounds should acknowledge the historical role of white colonists, land-owners and others over history, and that descending from these groups may have affect how they are perceived by the minority ethnic groups that work with and who were historically (and in some places currently) subjugated by them.

Musical meeting is possible

The literature is positive, however, about the role of music therapy in being a bridge between people despite difference of race or social status. Swinburne's (2013) survey of music therapists felt in music they could 'meet' their clients despite the

complex and fractured backdrop of South African society. Orth and Verburght (1998) witnessed the expression of emotions universal to all through music in their group with refugees. Hunt (2005) noted that while the teenage refugees in the music therapy group had needs relating to their refugee status, they had issues of identity formation and peer acceptance common to all teenagers. Music therapists build relationships based in universal emotions and our common humanity, finding a meeting place with their clients based in commonality.

Theoretical frameworks

Music therapists draw on a number of different theoretical frameworks depending on their orientation. The Community Music Therapy approach considers the (cultural) context in which the music therapy work takes place (O'Grady and McFerran 2007), and this may be of use to a music therapist from another school of thought who wishes to look at their clinical work from a different perspective.

A number of authors citied therapeutic boundaries as a place where the application of theory is overlaid with culturally informed beliefs, including ideas about self-disclosure (Dhillon-Stevens 2010) and time-keeping and limiting interruptions (Gadberry 2014). The boundaries of the therapeutic relationship are the interface of the therapy relationship with the therapist and client, and with the outside world and are the places where clashes will occur. It seems from the literature, however, that cultural factors in particular can come into play and are worth separate consideration, especially where one of the therapy dyad is from a culture where life is lived communally and time alone is unusual, and the other is from a society in which being alone with one other person and having privacy is more common. Navarro Wagner (2015) realised that her Western ideas about boundaries of time and place were meaningless in the context of her work in Uganda. A music therapist working in such

circumstances may have to re-examine and re-negotiate the boundaries they are trying to maintain in light of improved intercultural understanding.

Cultural empathy

Valentino (2006) identified four factors essential for effective cross-cultural music therapy practice; 'awareness of one's cultural context, knowledge of cultural factors, the use of cognitive and affective empathy, and the ability to effectively communicate empathy' (Valentino 2006 p. 110). Cultural empathy was highlighted by several authors (Chan 2014, Thomas and Sham 2014, Dhillon-Stevens 2012) as key to effective cross-cultural work. Cultural empathy is the ability to accurately perceive a client's experiences and feelings according to their unique cultural context. The therapist who unconsciously uses their own cultural identity as a yardstick to measure the experiences and reactions of a client from a different background risks failing to understand the other's experience and placing themselves behind a cultural empathy barrier.

Language

Although a language barrier proved a source of frustration for some researchers, music therapy provides a means of communication that does not depend on words. In fact, a lack of shared language could provide an opportunity for a client to speak freely, safe in the knowledge they can't be understood, although Bradt noted that a person who is not speaking in their first language is limited in their ability to express themselves fully (1997 p. 143). Language barriers are common, although not inevitable, when other cultural difference is present. Music therapists can sometimes make choices about whether they wish to work mainly in the music and side step linguistic barriers, engage an interpreter who will inevitably change the dynamic in the room, or use a client's second (or third) language. All of these have their benefits and limitations.

Working in the home

Entering into a family home is immersing oneself in the family culture. It provides the music therapist with an opportunity to understand the family's way of life, cultural rituals, and how they use music in a much deeper way than would be possible in a school or health care setting. This insider view changes the dynamic between therapist and family, placing the family on safe, familiar ground, and challenging the therapist to adapt their ways of working to fit in with the family's practices.

Special education and cultural safety

Following a survey of music therapists to determine their professional knowledge of working with clients with cultural and ethnic differences to themselves, special education was identified as an area where a particularly sensitive approach to cultural difference was required for working with both children and their parents (Toppozada 1995). When both the approach and the music are unfamiliar, care needs to be taken in building the relationship with parents and child. The concept of 'cultural safety' was discussed; when minority groups are able to identify and evaluate services through their own cultural perspective in partnership with statutory of other services. This attitude on the part of the music therapist of willingness to engage with families about the nature and effectiveness of what they are trying to provide can greatly improve the relationship.

Other barriers to engagement

Several of the authors found that in their work and research with people with different cultural backgrounds to themselves, a wide range of issues came into play that affected the music therapy work, such as gender (Zharinova-Sanderson 2004), race (Lightstone 2014), power and politics (Swinburne 2013). Attitudes to sickness, health and receiving help varied across cultures (Orth 2005, Chan 2014). Differences due to individualistic (sometimes described as 'Western') versus group oriented cultures

affected music therapy work. Cultures accustomed to a didactic or even paternalistic style of education and authority found the music therapists' attempts to find dialogues with their patients actually undermined their credibility (Bradt 1997). Musical differences were often not the sticking point, and musical meetings could be found despite the other barriers being present.

Music therapy training, supervision and continuing professional development

With increased migration, music therapists found they had an increasing need for training in effective cross-cultural work. A music therapist working with a patient from a different cultural background to themself may feel they need to examine this issue in supervision or in specific continuing professional development. Just as there was not a consensus across training courses around the world; some tried to develop their students' multicultural musical knowledge through knowledge of ethnomusicology, others drew upon concepts taught on psychotherapy and social work trainings such as cultural empathy and cultural safety; there were a range of suggestions for how an individual might develop their own awareness of good intercultural practice. Hadley (2014) argued that a music therapist should take steps to both examine their own cultural upbringing and values to better understand their responses, as well as takes steps to broaden their own experience through exposing themselves to difference through the arts, travel, increasing awareness of world issues and through varied social circles. Training courses, which often have students from a range of cultures provide opportunities to encounter different values. Supervision may be used to explore cultural issues in music therapy work, but where there is cultural difference between therapist and supervisor, this again may need careful negotiating for the relationship to provide the right grounds for openness and understanding.

Research

The potential for sensitively constructed research studies to further knowledge of culturally appropriate practice is great. Researchers suggested the use of paradigms that allow participants to be involved at many stages of research, including research design and validation of results such as Participatory Action Research, grounded theory. Through well-chosen methodology, the body of research into effective cross-cultural practice may be increased, but also links between different communities may be strengthened.

3.6.2 Sub questions

How do culturally informed perceptions about the function of music affect music therapy work?

Performance

Some societies do not separate music-making from performance. Although many patients who come to music therapy may be unfamiliar with music for purposes of therapy, it seems that for those patients who come from traditions when music is always performed, and always communal, the music therapists felt that it was important for them that the music created in music therapy sessions would be performed more widely. Even if a music therapist finds they are able to meet their patient musically, it may be that from the point of the view of the patient music removed of its customary cultural context is meaningless.

Musical instruments

Musical instruments may have a culturally assigned meaning that holds significance for music therapy sessions. Jones, Baker and Day (2004) described how the Luer tribe of Sudan use shakers to summon the dead, so when working with young refuges from this ethnic group exercised caution. Music therapists need to be open to

these factors when working inter-culturally. While it is not possible for a music therapist to learn about all traditions, when working with a number of people from a particular cultural group it could be possible to take time to learn about the musical traditions relevant to that group.

Perception of emotions

Research has shown that perception of both type and intensity of emotion in music are culturally dependent (Bright 1993). This is important as a music therapist may incorrectly interpret the emotion in a patient's piece of music (Bradt 1997) and assign false meaning. Music is sometimes considered a universal language, but research has shown this not to be the case, so music therapists must take care to check the meaning they are ascribing to a patient's music, either through talking to them or perhaps learning more about the way music is used in their cultural tradition.

Music has links with cultural identity: How does this relate to music therapy practice?

Researchers mentioned a number of pitfalls music therapists may encounter when music relating to a patient's cultural identity is used in music therapy sessions. Some patients wish to share the music of their cultural background; this might be in order to share something personal with the music therapist, for example in case of a person who is far from home, or has a great love for their culture. Others, however, wish to remove themselves from their past, sometimes due to bad associations with their homeland, or they want to embrace their new context, or they don't want to be seen as different by people from their new community. Music therapists described playing the music of their patient's cultural heritage and failing to capture to authentic spirit of the music. This led to a mis-matching and distancing effect, and even in Pavlicevic's (1997) example to outright hilarity from the group at her failed attempt at playing in their cultural style.

As much as music provides a close link to cultural identity, great care should be taken in incorporating this into music therapy sessions, by following the patient's lead. There can be great benefits, but there can be a risk of inauthenticity in the music, which might damage the relationship. Where the minority cultural background of the patient was shared by the therapist, great benefits were observed; the musical therapists found they were able to form a deeper relationship more quickly, and they experienced greater levels of understanding and acceptance.

3.7 Conclusion

The literature available on the subject of cultural difference in music therapy raises many issues for consideration amongst music therapists. From the musical instruments and the way the music is played to the wider considerations about language, gender, inequalities and privilege, cultural considerations have been observed at many levels of the music therapy relationship. There are a small number of formalized research projects looking into this topic, mostly from the perspective of the music therapist; a number of researchers are utilizing paradigms that increasingly involve music therapy patients in their design. Some general issues have come to the fore, but are applied differently by culture and then also by individuals. Music has strong links to culture, but individuals in music therapy have strong and opposing views about whether they want to use it. Music therapists must create a balance of cultural learning, a person centred approach, and awareness of the impact of cultural factors to practice effective, culturally safe, culturally empathic music therapy.

Chapter four

Background to the clinical work

4.1 Introduction

This chapter describes the two schools in which the clinical work took place. A general description of each school is given, as well as information on the ethnic demographics of the pupils and local area. The chapter goes on to describe the history of music therapy in each school, with a description of the music therapy room and instruments at the time the clinical work took place. I will then go on to talk about the process of setting up the research project at each school. Finally I describe my music therapy approach.

4.2 Descriptions of the two schools: Greenway School and Allen School[1]

The two schools in which the clinical work for this research project is situated have several similarities. They both serve a group of students with profound and multiple or severe learning disabilities, with some students with autism spectrum disorders, or requiring additional medical support. They both have a greater proportion of children from Black and Minority Ethnic backgrounds than the national average, and also a higher proportion of pupils qualify for the Pupil Premium, a fund to raise the attainment of disadvantaged students that includes the provision of free school meals.

4.2.1 Greenway school

Greenway school is a special school in the north of England, set in a residential area just outside a small town. It has around 120 pupils. 42% of pupils qualify for the Pupil Premium, a figure well above the national average; this indicates that many of the

[1] The real names of the schools have been changed to maintain the anonymity of the participants and their families

[2] Figures from Office for National Statistics 2011 census, http://www.ons.gov.uk.

pupils are considered to be disadvantaged in some way. The school is situated in an area with a high proportion of people from black and minority ethnic backgrounds, mainly Pakistan and other south Asian nations.

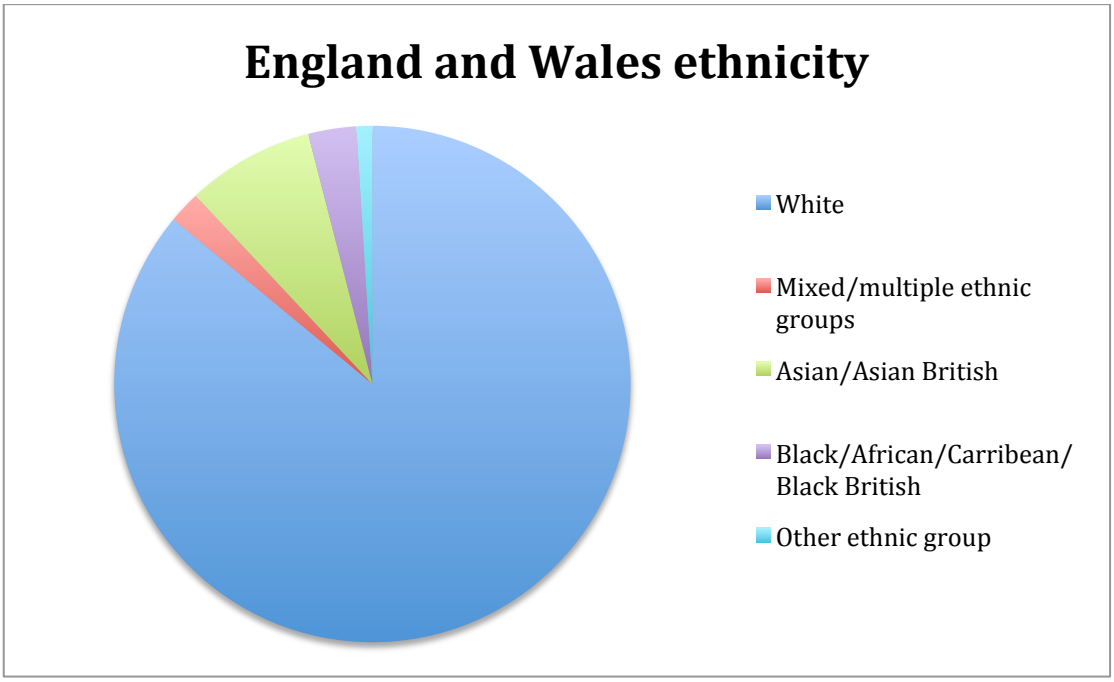


Figure 3. Pie chart to show ethnicity data for England and Wales[2]

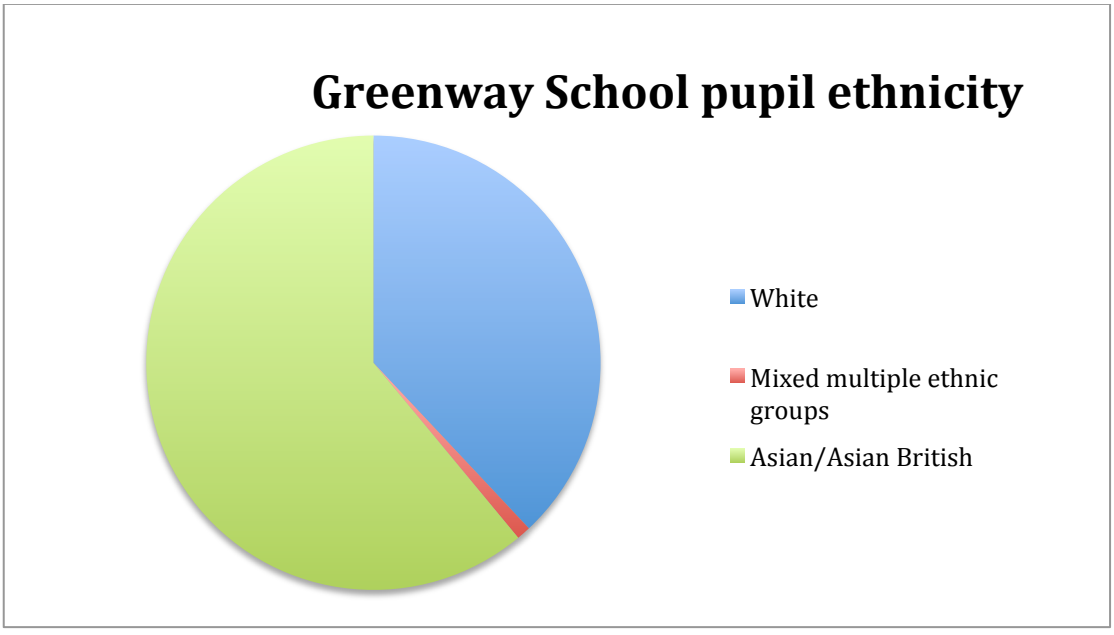


Figure 4. Pie chart to show ethnicity data for Greenway School

[2] Figures from Office for National Statistics 2011 census, http://www.ons.gov.uk. No further information on source given to protect the identity of participants.

The school's catchment area has a higher than average proportion of people from South Asian backgrounds. 62% of the pupils are from black and minority ethnic backgrounds (52% Asian/Asian British Pakistani, 9% Asian/Asian British Indian, Mixed White Asian 1%) see Figure 4.2 above. South Asian religious festivals are celebrated within the school alongside other world festivals, evident from the colourful display boards; bhangra, Bollywood and Western pop music is played in assemblies, and pupils make bhajis and samosas in cookery classes. Many of the school staff; teachers, classroom assistants and other support staff are also from Pakistani or Indian backgrounds, and speak the languages of those countries; this contributes greatly to the ease with which staff and parents are able to communicate. The school has a friendly atmosphere; the staff are very busy and there are not enough rooms, everybody knows each other and children passing in corridors are greeted with hearty enthusiasm and affectionate nicknames.

4.2.2 Allen School

Allen school is located in the suburbs of a large city in the north of England. While the immediate area around the school is a predominantly White British area, the school catchment area reaches across the city, whose ethnicity statistics more closely reflect the average for England and Wales.

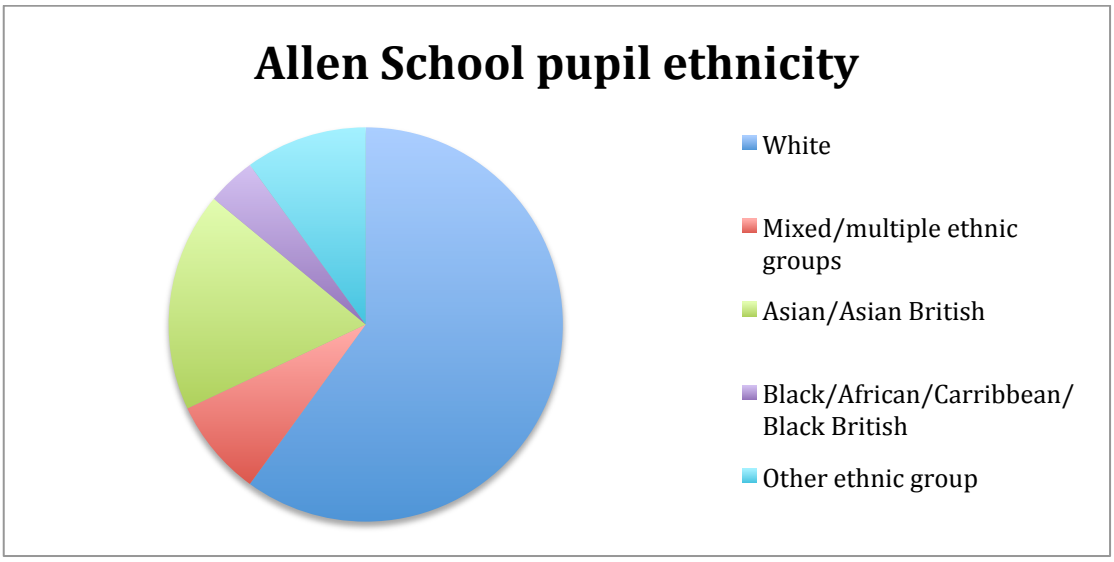


Figure 5. Pie chart to show ethnicity data for Allen School

N.B. The category 'Mixed' refers to Mixed White and Black Caribbean, Black African/Asian/other, 'Other' refers to Other ethnic/Black African/other Asian/white

With approximately 150 pupils between the ages of 11 and 19 it is located on the same site as a secondary school, and a few of the pupils are registered at both schools. The pupils at Allen school all have severe or profound learning disabilities, and a tenth are on the autistic spectrum. Around a third of the pupils qualify for the pupil premium; similarly to Greenway school this figure is above the national average. The pupils of Allen school represent the diversity found in the city in terms of range of different ethnic groups, although with a higher proportion of pupils from Black and Minority Ethnic backgrounds: see Figure 5 above.

The school is situated in a modern, two storey building with spacious, curving corridors and light open areas. I was struck, on spending time in the school, by the calm feel of the place, unlike the warm but harried, hurried atmosphere of Greenway School. Allen School also celebrates the cultural diversity of students and staff; near the entrance is a world map showing all the nations represented at the school. The

school's outstanding Ofsted report highlighted their links with local communities, including a recent project teaching sign language to staff at a local mosque school.

4.3 Music Therapy at the two schools

The existing shape of music therapy provision at the two schools is now described, so the clinical work part of the research project can be placed in context.

4.3.1 Music therapy at Greenway school

Greenway School employs a music therapist one day per week to work with groups and individual pupils and has done so for three years. I was the first music therapist to hold the post and left it to commence this research, at which time they employed another music therapist to continue the music therapy provision.

At the beginning of each school year and of each term, the deputy head and/or class teachers meet with the music therapist to discuss potential referrals. These pupils are selected based on their level of need to receive this extra intervention. Selection for music therapy can also depend on whether a suitable group has been constructed that the pupil may join. As part of the referral process for an individual, the class teacher and music therapist will discuss potential aims for music therapy sessions. They may also draw on the Personal Learning Plan for the child, a document that describes the child's abilities in a range of areas. (This document can be particularly useful when meeting with a teacher who is unfamiliar with music therapy practice, as it can be used to show the many areas in which music therapy can support a child's development, rather than music education or entertainment). There is then a music therapy assessment period, usually of two sessions' duration before, if indicated, weekly sessions commence.

The school sends Teaching Assistants (TAs) into all music therapy sessions. When the music therapy post was first set up, the school was keen that this would be the case for all music therapy sessions. They gave several reasons; some of the children had medical needs, including regular seizures that required the presence of a trained member of staff; they had concerns that the music therapist might not be able to cope in the instance that the pupil exhibited some behaviours which challenged them. I also felt, however, that as the school had not had a music therapy service before there was a level of interest, even curiosity about what would happen in sessions and this motivated the presence of their own staff. On the condition that the TAs attending music therapy sessions accepted my understanding of confidentiality within this setting, and the same TAs attended each week, I was happy to go along with the school's suggestion. As it turned out, the TAs were very positive about the music therapy sessions and became powerful and effective advocates for music therapy throughout the school.

4.3.2 The music room and instruments at Greenway School

The pupil numbers at Greenway School have expanded beyond what the building was originally designed for, so at any time they have very few spare rooms. For the music therapy sessions I would be conducting as part of the clinical work for my research project, I was assigned the family meeting room, where I had previously worked when I was employed by the school. This small, pleasant, semi-circular room has windows all the way around the curved side, with armchairs in front of all the windows and plants along the sills. It is also used as the prayer room for female Muslim staff every lunchtime, so contains a sink and prayer mats. It is calm, tidy, and the plants and armchairs in particular give it a feel very different to that of classroom.

Since I started using it as the music therapy room it also contains a piano, and during the research project I brought in my own instruments in addition; a djembe, ocean

drum, a guitar and a number of small percussion instruments. I also brought my flute. This is the instrument on which I am most proficient and I often use it in music therapy sessions as it is the instrument with which I am able to communicate and respond most fluently. The main drawback is that unlike all the others instruments, I cannot offer it to the child I am working with to play, so I do not use it in some sessions if I feel this would be frustrating for the child.

4.3.3 Music Therapy at Allen School

As far as the Head of Performing Arts, a long-standing member of staff, was aware, Allen school had never had a music therapist working there before this research took place. The school does, however, have a very active music and performing arts department; school ensembles have performed at prestigious venues and won national prizes. While this is, of course, not the same as a music therapy service, I felt it shows the school places value on the role of music and the arts in the lives of the pupils it serves.

I gained an introduction to the school through a social contact who was employed there, and after meeting with the Head of Performing Arts and describing the project they were very open to hosting the research, as I will describe in the sections below. During these initial talks with the Head of Performing Arts I described typical reasons for referral and aims of music therapy, and how a referral and treatment process might fit into a school such as theirs. I will explain this in further detail below.

4.3.4 The music room and instruments at Allen School

Allen School had a large drama studio and music room with a wide selection of instruments. Unfortunately this room was not available on the day I was able to come to the school, but they were able to find a large classroom for me to use, and I was free to borrow any of their instruments.

The classroom was full of furniture, upon which objects and artwork were found such as drying paintwork and piles of pine cones, in addition to full bookshelves, cupboards full of equipment, and a wall of sinks. The large space felt cluttered, and it was much more difficult for me to tidy potentially distracting or hazardous items out of reach than in the room at Greenway School. Two of the children at this school were able to move freely around the room, and all these items proved distracting. It is my preference, when working with children who may wander around and explore their environment, to clear the room I am working in of all items except musical instruments, so that anything the child picks up or moves is 'permitted' and can create an opening into a musical interaction. I borrowed two large djembes from the school store, and brought my own guitar, ocean drum, flute and small percussion.

4.4. Setting up the research project

The process for setting up the research project at each of the two schools was slightly different, both because of differences in the existing music therapy provision at each school, and for other, more subtle factors such as the existing understanding of music therapy, and the level of support provided by each school in setting up the project.

4.4.1 Setting up the research project at Greenway School

When I left my music therapy post at Greenway School to pursue my doctoral studies, the deputy head encouraged me to stay in touch, and to consider the school if they were a suitable venue for the research. Therefore, when I contacted them to ask if they would host part of the research they were very keen and accommodating. They provided me with a letter to this effect, as did Allen School, a requirement of the ethics committee.

One of the first areas for consideration was that there was a new music therapist in post, so I met with her early on to discuss how my clinical work might fit around her existing caseload and also her timetable, as we would be using the same room for music therapy sessions. As dictated by my methodology I would be working with any child who followed the usual referral criteria, and also had English as an Additional Language, or English was not the first language spoken at home. After she had spoken to the class teachers, the deputy head came up with a list of pupils she felt suitable for referral to music therapy, and fulfilled the inclusion criteria of having English as an Additional Language. I then took this list to the music therapist who checked the pupils were not on her previous or current caseload.

Five children were chosen, and the families of those children were invited to attend a meeting to find out about the research, about music therapy, and to give them an opportunity to ask questions before giving consent to participate. We scheduled this on the day of a coffee morning the parents would already be attending, for their convenience and to ensure good attendance. I knew that although most parents spoke good English, one parent did not. I asked the school about their procedure for providing translation when communicating with this parent and the school, in line with their usual practice, arranged for one of the TAs to be present who speaks the same language dialect as that parent.

I gave a presentation on music therapy including video material of my work with a child with similar needs to many of the pupils at Greenway school. (While I find video is always extremely useful when describing music therapy work, it becomes even more helpful when there is a language barrier). I went on to describe the research, including the requirement that the parents attend as many of the sessions as possible. I gave the parents participant information forms and consent forms that

included consent for video (see Appendix 1-4 for participant information and consent forms).

The parents had many questions and comments. One mother wished to see a music therapy session with her son before agreeing to participate. We arranged that we would have the two assessment sessions then she would decide at this point whether or not she wished her son to continue his participation in the research project. Most of the parents were reluctant to consent to video recording. We talked through what the video material would be used for, and four out of the five consented for video to be used for professional purposes. One parent wished to have a copy of all the video recordings taken of his child. Three mothers and two fathers were present at the meeting, representing the five selected children. I was struck by the fact that the mothers all signed the consent forms at the meeting, whereas the fathers all took the forms home for their wives to see.

Following discussions around the research, consent and video consent, the parents and myself agreed a timetable between us, and a date for the first music therapy session. In the weeks after the meeting, one parent was in contact to decline their involvement in the research project as they felt it would be too difficult to attend sessions due too the distance involved. The school found another family who was willing to be involved and distributed the consent forms to them.

4.4.2 Setting up the research project at Allen school

Allen school had never had a music therapy service, so had no existing referral pathway for me to use as part of my process of identifying participants. Therefore, I used as similar an approach to Greenway school to maintain as much consistency as possible in my approach across the two locations. I had a meeting with my link person at the school, the Head of Performing Arts, at which I gave an explanation of

music therapy, the kinds of goals a music therapist might work towards in this school setting, and of the research project with the inclusion criteria that the subjects would have English as an Additional Language. She then in turn liaised with class teachers who would know both their students and their needs, but also their families and if the pupils would fit the inclusion criteria. She came back to me with five potential referrals, and we arranged for a meeting to meet with the families of these children.

Three out of the five parents who were invited attended the initial meeting, which took the same format as at Greenway school. Again, the parents found the video material particularly useful and I felt they were more receptive to the idea of their children receiving music therapy once they had seen the video. One of the children suggested for the project was an orphan under the guardianship of her adult siblings. The sister who attended the meeting had many questions about the video consent involved in the project, requiring correspondence over a couple of weeks. Despite my reassurances that video recordings were not a requirement of the research project, she eventually declined her family's involvement in the project giving the reason that because the family is Muslim they preferred to avoid the use of video recordings. I felt that this might be an excuse to avoid involvement; I had been very clear that video recordings of sessions were not required. I felt rather that they had decided that they didn't want to be part of the research project for another reason, which of course is their right, and the reason for going through process of having participant information meetings, and the information and consent forms; so the potential participants and their families have a thorough understanding of what is involved.

Following the meeting my contact at the school found another family willing to participate. Consent was duly obtained from this family.

4.5 Meeting with an Imam

Shortly after the participant information meetings I arranged a meeting with a local Imam who is an expert on multi-faith work with an interest in cultural awareness and community cohesion. Many of the families involved the research project were Muslim, and although I had worked with many Muslim patients in the past, I had a great interest in furthering my understanding of working with this group, something I had not had the time or opportunity to do as part of my regular work as a music therapist. This research project, however, gave me the opportunity to explore further this aspect of my practice.

A personal contact put me in touch with this particular Imam as someone who was well qualified to provide insights into the British Muslim community. I am not naming him in this thesis as it would locate my study, and therefore the participants. We met in person and spoke about Islam and music, family life and parental roles. He also answered my specific questions about music and about the use of video recording; an issue raised by one of the families in a participant information meeting.

We discussed the place of music in Islam. He said that singing, clapping, segregated dancing and the playing of a one sided drum is described in the Qur'an so could be considered as permitted from the Sharia point of view, but the use of other types of instruments was a matter of opinion. He gave the example of Qawwali music from the Sufi tradition of Islam, which is designed to send the musicians and audience into a trance. He also said that my instrument, the flute, is famous in Muslim cultures as many people who were shepherds or drove camels would have a flute and used music to get away from their loneliness.

The Imam said that in Islam the mother is given more rights than the father, especially in terms of running the household. If the parents separate, children before

the onset of puberty go to the mother. The Prophet said that the mother's rights are three times those of the father. When the Imam mentioned this to me I told him that in the participant information meeting with five Muslim families, the three mothers signed the participation forms immediately whereas the two fathers took the forms home for their wives to see and he said that he thought this was due to the cultural-religious role of the mother being in charge of the children and household.

I asked the Imam specifically about the family who withheld permission for video recording sessions, attributing it to their Muslim faith. The Imam wondered if they might have been concerned about their privacy. He said that in Islam making images of God and the prophets is forbidden but that photos and videos do not come under this category; the precept rather relates to making images to be worshipped. He also observed with humour that every sect, no matter how orthodox, has videos on YouTube.

4.5.1 Reflections on meeting with Imam

I found the experience of meeting with the Imam very useful to my clinical practice and also informative to my role as a researcher with minority ethnic groups. I did not expect to learn information I could then apply to all the Muslim families in my research, and the Imam did not represent himself as speaking for all Muslims. Rather, I was able to broaden my understanding, which included a selection of musical examples the Imam suggested I listen to: nasheeds, recitations of the Qur'an, and qawwali music. While I do not want to go into a new therapy relationship with assumptions already in place about the worldview of the person I am working with, this detailed conversation about some of the above subjects gave me more confidence in engaging with the families.

4.6 My music therapy approach

I completed my Masters degree in music therapy at Anglia Ruskin University, Cambridge, in 2009. This has been the biggest influence on my music therapy approach, which is based in free improvisation, psychoanalytic theory and knowledge of child development, particularly theory around early infant interaction as developed by Stern (1985). My personal tutor, placement supervisor and now PhD supervisor, Prof. Amelia Oldfield, particularly influenced my approach in her overt 'use of music as a means to achieve non-musical aims' (Oldfield 2006 p. 22). This aims based approach is a key part of my work in special schools and in the clinical work for this research project. While music therapy sessions have a free, playful and unstructured character as I follow the child, I retain a focus on these aims and communicate them with parents and teachers regularly (Oldfield 2006 p.23).

My music therapy sessions start with some kind of musical marker to show the beginning of the session; usually a 'hello song'. Following this, I invite the child to choose instruments and I improvise with them. Alvin pioneered the free improvisational model of music therapy, with the following characteristics:

- 'All the client's therapeutic work centres around listening to or making music.
- Every conceivable kind of musical activity can be used.
- Improvisation is used in a totally free way, using sounds or music that are not composed or written beforehand.
- By sounding the instruments in different ways, or by using unorganized vocal sounds, inventing musical themes allows great freedom.
- Free improvisation required no musical ability or training, and is not evaluated according to musical criteria.
- The therapist imposes no musical rules, restrictions, directions or guidelines when improvising, unless requested by the client. The client is free to

> establish, or not establish, a pulse, metre, rhythmic pattern, scale, tonal centre, melodic theme or harmonic frame'
> (Wigram, Pederson and Bonde 2002 p.131)

Much like Alvin's approach the whole focus of my sessions is music making of all kinds. The core elements of music are 'pitch/frequency, tempo/pulse, rhythm, intensity/volume, duration, melody and harmony' (Wigram 2004 p. 35) and these are explored freely by myself and the child. A very wide range of vocal sounds and methods of playing the instruments are possible (as long as neither people nor instruments are harmed), and I endeavor to engage as freely as the child in exploring the world of sounds.

The music therapy sessions are a non-judgmental environment; I consider any sounds the child makes as communication so offer neither praise nor criticism. TAs attending sessions sometimes struggle with this idea, as they might offer a well-meaning round of applause or enthusiastic praise. I explain to them that I try not to give value judgments on the music; the music therapy session is a space where all feelings, good and bad may be communicated and shared.

Wigram describes clinical improvisation as 'the use of musical improvisation in an environment of trust and support established to meet the needs of clients' (Wigram 2004 p.37). Unlike Alvin's purely free improvisational approach, Wigram also includes musical structures of different types, including 'frameworking' in particular musical styles such as jazz (Wigram 2004 p.121). As well as the 'hello' and 'goodbye' songs, I sometimes incorporate pre-composed music such as favourite nursery rhymes if requested by the child, or action songs. I follow the child in this instance, however, including such music if they seem to enjoy it or if they ask for

more, while always keeping in mind the aims for the sessions and the wishes of the child.

Watson, in her music therapy work with adults with learning disabilities, finds useful parallels with Stern's descriptions of mother-infant interaction, as well as Intensive Interaction, which was also developed using knowledge of early interactive methods and 'uses playfulness, spontaneity and sensitivity in interactions, to make and develop relationships with clients (Watson 2007 p.102). Playfulness and humour are present throughout many of my music therapy sessions. Often, the most effective means of achieving my identified therapeutic aims is through enjoyable, motivating, amusing interactions.

Finally, my music therapy approach is also influenced by my personality. From reflection on my manner I would say that in music therapy sessions I am calm, gentle and approach people with warmth.

4.7 Conclusion

This chapter has provided a description of the two schools in which the clinical work was situated, with detailed information about the ethnic origins of pupils in each school. The process of gaining informed consent from families and setting up the clinical work has been described. I have also described my meeting with a local Imam and set out my music therapy approach.

Chapter five

Case studies

5.1 Introduction

This chapter contains eight music therapy case studies for the eight young people involved in this research. The methodology for writing the case studies is reviewed before the eight case studies are set out. The case studies comprise part of the data for this research along with the literature review and findings from the thematic analysis of parent interviews. The case studies are reflected on and conclusions are made with reference to the research questions.

5.1.1 Summary of research case study methodology

The rationale for the methodology adopted for the case studies is set out in greater detail in chapter two, but a summary of methodological procedure is provided below. Research case studies are used by music therapists to provide a detailed account of the music therapy process; 'a *thick description* of complex interactions in a natural context' (Smeijsters and Aasgaard 2005 p. 444). Research case studies are set out following a systematic process. I have designated the steps below for the production of the following eight case studies based on steps suggested by Smeijsters and Aasgard (2005 p.445-446)

1. The defining of a specific activity or event over a fixed period of time.
2. A research goal based on in-depth understanding and analysis of the case.
3. A qualitative methodology linked to the research goal.
4. Ensuring trustworthiness through checks; repeated analysis, supervision, personal reflection.
5. Triangulation of multiple sources of data: case notes, video material, reports, researcher diary, supervision notes.

6. Narrative account of each case study including thick description and researcher's reflections on the case to help demonstrate the sources of evidence.
7. Examination of the case studies from the point of view of the research questions

As described in chapter four, the clinical work for the eight case studies took place across two sites, Greenway School and Allen School. The children were referred for music therapy following the usual practice for that school, and then the inclusion criteria was applied; that English was not the first language spoken at home. The music therapy sessions took place over a period of twenty weeks.

I kept clinical notes of the music therapy sessions in my customary manner for that setting, chiefly detailing progress towards identified aims, general observations from the sessions and suggestions for the following session. In addition to this I kept a researcher diary, as described in the Methodology chapter. The purpose of this diary was to record my observations from the music therapy sessions that connected with the research project that I would not usually put in the clinical notes. The researcher diary was also there to help me record my reflections and responses to aspects of the clinical work relating to the research topic in my other role as researcher, thereby assisting me to become aware of and limit researcher bias.

The case studies were drawn together from the clinical notes, researcher diary, the end of therapy reports I prepared for the school and the parents, and from reviewing the video recordings of sessions. The case studies are each set out in a format based on the end of therapy reports. Information is given on the reasons for referral, assessment sessions, the clinical aims for therapy arising from assessment, the child's progress towards those aims, the parents' role within sessions and

recommendations for the future. The case studies then contain further information from the researcher diary on any aspects of the clinical work that would not usually go in the clinical notes, but are of relevance to the research project.

5.2.1 Case study one: Saif

Referral

Saif was referred for music therapy as it was felt by his school that he could benefit from a more intensive one-to-one intervention and a new means of non-verbal communication. He was also currently unable to attend school as he was recovering from two years' serious illness involving several lengthy stays in hospital. The school thought weekly music therapy sessions would be a good addition to the input the school was providing in the family home with a view to preparing Saif for a return to school the following term. As well as weekly music therapy sessions, he also had visits every day from his class teacher or one of his teaching assistants to build up his daily routine.

Background

Saif was 14 years old at the time the clinical work took place. He is one of five siblings, three of whom are disabled. Alongside his mother and father who are full-time carers to their children, a team of PAs (personal assistants) goes into the house to help care for him and his siblings. Saif has a cerebral visual impairment, poor muscle control, severely impaired communication and requires time to process information.

When I first met Saif, immediately prior to our first assessment session, he was lying in his bed, in his bedroom. Although there were personal items around, the hospital style bed and amount of medical equipment gave it something of the feel of a hospital room. Saif had a pleasant, smiling face and giggled, laughed or vocalised

often. His limbs and face were often mobile, and he seemed to have a gentle, content character.

Assessment

Saif had two assessment sessions. These, along with the majority of his music therapy sessions took place in his bedroom, in the family home. The final few sessions took place at school as Saif made the transition back into school attendance. I began by singing a greeting song accompanied on guitar to mark the beginning of the session and acknowledge Saif by name. I went on to offer him a number of musical instruments to play before finishing with a goodbye song. Saif vocalized occasionally and smiled when I played the guitar, slit drum and flute, although it was difficult to identify a clear cause and effect to his responses.

Aims

After discussion with Saif's parents and teacher, the following aims for Saif's music therapy sessions were decided upon:

- To provide opportunities for Saif to hear and play musical instruments with a variety of timbres and ranges of sound
- To encourage interaction through vocalizing and playing musical instruments
- To encourage use of the hands and voice
- To develop a relationship with a new person; the music therapist

Progress towards aims

<u>Variety of instruments/sounds</u>

I brought a selection of instruments each session for Saif to hear or play; percussion, melody and harmony instruments. Saif seemed to show a preference for melody and harmony over percussion, although the instrument he chose to play for the longest

duration was the cabassa (an African percussion instrument with an unusual texture consisting of a gourd wrapped in a net of little shells). He grasped this instrument and moved it around energetically.

Encouraging vocalization

Saif vocalized for much of the time in music therapy sessions. I encouraged this by vocalizing myself, leaving pauses, imitating and developing the sounds he made, and sometimes creating a musical (harmonic or rhythmic) structure around our vocalizing using either the guitar or slit drum. Saif seemed to wait and listen, then respond to my vocalisations, just as I did with his and we had many dialogues in this manner. On one occasion Saif's elder brother observed a music therapy session. He greatly enjoyed watching our interaction and said it was like Saif and I had made a language of our own.

Developing relationship

The music therapy sessions always began and ended with the hello and goodbye songs to help Saif understand the routine, and that the music therapy session was taking place. I felt that Saif began to recognise the hello song. He often seemed to listen intently as I set up my equipment in preparation for the music therapy session then start smiling, laughing and vocalizing when he heard the hello song. Over the weeks and months, as Saif and I got to know each other, we established a familiar routine.

Conclusions

Listening, waiting and responding formed the basis of communication, and were a central part of the sessions. Through music therapy sessions, Saif had the opportunity to interact with the music therapist vocally and using instruments. He also had opportunities to hear and feel a range of musical instruments, and seemed to

greatly enjoy the interactions. It seemed like my music therapy approach involving waiting and following the lead of the child enabled Saif to really take his part in the dialogue we created.

Reflections from researcher diary

Sessions in the home environment

Seeing Saif in his home created quite a different dynamic to that if sessions were taking place in the music therapy room at school. As I was entering into the family home and the family's space it was necessary for me to fit in to their routine and family culture. As a Muslim home this involved removing my shoes at the door, and receiving a warm welcome. One or both of Saif's parents would be present for the beginning of the session, but they would often leave and return at another time. When they left, the door remained opened; I felt this set a precedent that I could not break, even though at other times I am accustomed to working behind a closed door. At one time or another both parents, an uncle, a brother, and two P.A.s came in to the session. Owing both to the fact I was a guest in the home, and Saif's experience as a severely disabled child accustomed to having these people around him meant I felt I should be flexible with this boundary.

Music

Conducting music therapy sessions in Saif's bedroom gave me a rare opportunity (for school-based music therapists) to experience what his daily life was like; in this instance his daily life at home. One striking feature of the bedroom was that there was a large television mounted on the wall opposite Saif's bed. Although his vision is impaired it is thought he can see shadows and lights if the room is dark. Saif's parents told me he likes to watch Bollywood films. When he has fits, they play CDs of chanting from the Qur'an. They said the sounds soothe him. I got the sense the parents themselves got spiritual support from the religious chanting.

5.2.2 Case study two: Baraq

Referral

Baraq was referred for music therapy by his class teacher to develop his communication skills and concentration.

Background

Baraq was twelve years old. He had a diagnosis of Autism Spectrum disorder, with verbal language limited to a handful of words. He was mobile; able to walk around without much difficulty, although sometimes a little unsteady on his feet.

Assessment

During the first assessment session, Baraq seemed a little shy, but with his mother's encouragement he tried some of the instruments. He seemed to be interested in playing the instruments in both of the two assessment sessions, but only played any of them for a very short time before moving on to the next one. Having only a small selection of instruments available in the second assessment session seemed to help him focus a little more. Also, as he seemed full of energy, encouraging Baraq to stand up and move around the room appeared to help him to then settle down and focus on the musical instruments. I felt that he had a creativity and energy within him that was often thwarted by his limited movement and language, possibly leading to frustration at times. On the whole he seemed a good-natured and happy boy.

Aims

Following discussion with Baraq's mother and class teacher, a number of aims were decided upon for the music therapy sessions. They were as follows:

- To provide opportunities to develop turn-taking and listening
- To increase concentration and length of time spent on a task

- To give Baraq opportunities to explore different moods and emotions through music

Progress towards aims

Turn-taking and listening, exploration of different moods

Baraq enjoyed making dramatic sounds and exploring different emotions through the music. He liked to make a dramatic sound then wait for my reaction, which I supplied in similarly dramatic fashion. The sounds he made were designed to elicit different reactions from me; fear, surprise, amusement. When I reacted in a comedic, exaggerated manner to his sounds he found this very funny. I supported these interactions with improvised music to create some structure, then used this structure to regain a little control in the interaction myself; it felt that Baraq was in control for a lot of the time, so creating a role for myself in the dialogue meant the balance of power could be spread more evenly.

Concentration

Baraq was clearly motivated by the music, so at times was able to sit with me and remain engaged in a musical interaction for some time. I tried to use a mixture of supporting Baraq with a musical structure of some kind, whilst allowing flexibility to respond to his reactions or contributions.

When his mother was attending a session, however, Baraq was much more easily distracted, moving around the room between different instruments and not settling. He also spent time moving his mother around; directing where she should sit and whether or not she should speak or play. Baraq's mother told me that he loves flash cards (cards with a picture and the written word underneath), so I made a set with pictures of the instruments we used in sessions (they may be found in Appendix 6). I used these cards to draw Baraq into musical games, for example, we would each

draw a card at random then play together whichever instruments were depicted. The flash cards enabled us to play together through a structure Baraq understood. On one occasion in particular, we used the flash cards to choose our instruments then the three of us played together on a seemingly equal footing. Baraq even followed his mother's lead an a few occasions, something very unusual for him in the music therapy sessions.

Conclusions

Baraq was able to use music therapy sessions to explore emotions, and develop turn-taking, waiting and listening skills. He was motivated by the music and musical instruments, and once I had adapted the sessions by limiting the number of available musical instruments and incorporating flash cards, Baraq, his mother and I were able to share some prolonged musical interactions.

Reflections from researcher diary

Parent involvement in sessions

On seeing Baraq and his mother together, I was struck by how much he controlled her, ordering her to sit in a particular place, then move, to play or not play. It felt like this was a well-established dynamic. He also seemed to deliberately favour me at times as if to emphasise her lower role. This made me feel uncomfortable as I was aware I was being played off against his mother. She understood his actions, however, and did not seem to mind. I deliberately resisted his actions at times to try and disrupt the balance of power (which was usually in his favour). The flash cards were also helpful as we could allow them to decide who would play which instrument and add a kind of equality.

5.2.3 Case study three: Hameed

Referral

Hameed was referred for music therapy by his class teacher to give him an opportunity to develop communication and choice-making through the medium of music and have enjoyable one to one attention.

Background

Hameed is a seven-year-old boy with global developmental delay and physical disabilities. He uses a wheelchair and has limited control of his limbs. He is physically quite small with big bright eyes, long eyelashes, a ready smile and a sense of gentle mischief. He can often be seen looking around his environment with an alert, eager expression, and smiles in response to eye contact and to people using his name. He has no verbal language, but makes occasional vocal sounds.

Assessment

Hameed had two assessment sessions, the first one attended by his mother and father, and the second one without. Hameed appeared to greatly enjoy the music and musical activities, listening intently when I sang songs and reaching out to play the instruments offered to him. He especially enjoyed dropping the instruments on the floor and the subsequent response elicited from the adults in the room ('Oh no! It's fallen on the floor! What *shall* we do?' in a dramatic style etc.); this made him laugh heartily.

Aims

Following the two assessment sessions and discussions with his parents, the following aims for music therapy sessions were decided on:

- To give Hameed opportunities to make choices and have control over his environment
- To develop turn-taking and dialogue through musical interactions
- To promote vocalization
- To express emotions and have fun

Progress towards aims

Choice and control

In every music therapy session Hameed was given choices between two musical instruments at a time, a level of choice making that was also used in his classroom. When given two options in this manner he was able to indicate his preferences clearly. With some of the larger instruments, for example the ocean drum and guitar, Hameed would play them for a while before dramatically pushing them away with a crash and laughing out loud. I often improvised a song around his actions; I gradually increased the intensity of the music until he pushed the instrument and broke the tension. He remained in charge of the activity and seemed to really enjoy the moments of suspense and build-up he would create before the instrument came crashing down.

Turn taking, dialogue, vocalisation.

Hameed vocalised enthusiastically, usually with a rising ‘ah-ah’ phrase. I would imitate this, to his delight, then we would continue taking turns at making similar vocal sounds for some time. I often varied my vocal replies slightly to try and expand his vocal repertoire. Hameed’s mother and I both noticed that his range of vocal sounds increased over the period when I saw him for music therapy.

Having fun

Hameed enjoyed many aspects of the music therapy sessions, including those described above. He also enjoyed interactions involving funny vocal noises, for example when I imitated the sounds of the instruments, or when I made amusing or dramatic body movements or facial expressions.

Conclusions

Hameed greatly enjoys music and clearly had a lot of fun in music therapy sessions. Music and musical sounds motivated him to interact with others through vocal sounds and musical instruments. Music therapy sessions gave Hameed a means of making meaningful choices based on his interest in the music and instruments, and therefore a means of control over his environment and the people with whom he was playing music.

Reflections from researcher diary

Parental involvement in sessions

While not necessarily a cultural phenomenon, something I found difficult in Hameed's sessions was his parents' involvement. In the first few sessions especially, his mother and father enthusiastically took part and even led activities. I had to carefully negotiate a line of maintaining their involvement and enthusiasm whilst allowing time and space for Hameed to take a lead. As the weeks went by, the parents began to understand my approach more and leave more space for Hameed, without any need for discussion or my seeming to impose any limits on them. Although this ended up working very well I felt anxious to start with and had to be patient that Hameed and I would be given space to work towards the identified aims for the sessions. It was clear to see that the music therapy sessions give Hameed's parents precious, happy time to enjoy being playful and creative with their son.

5.2.4 Case study four: Maruf

Referral

Maruf was referred for music therapy by his class teacher to give him opportunities for non-verbal communication and expression, and enjoyable one to one attention.

Background

Maruf has global developmental delay. He has no language but makes vocal sounds. He is sometimes able to make choices between two objects by directing his gaze at his object of preference; his class teacher is helping to develop this kind of choice-making with him in lessons.

Assessment

Maruf had two assessment sessions; one with his parents and one without, at their suggestion. I thought that he seemed interested when I started playing; his mother confirmed that this was the case. He reached out to the guitar when it was offered to him, and moved his hand across the strings. He also played the cabassa and shaker. Maruf played the wind chimes for some time. The nature of this instrument meant that he was able to generate a lot of sound from relatively little movement and it seemed to capture his interest. In the second assessment sessions Maruf seemed less animated than in the first. He smiled occasionally and played the guitar again. He seemed to have a cold and some difficulty breathing, which could have accounted for his quieter mood

Aims

After meeting with Maruf's teacher and with reference to his personal learning plan (the document produced by the school for each pupil that provides a baseline in a

range of skills connected with learning and development and highlights targets over the coming year), the following aims were decided on:

- To provide opportunities for choice-making, including encouraging consistent use of eye-pointing to select instruments
- To give Maruf opportunities for control over his environment/other people
- To encourage use of the voice as a means of communication through vocalising/singing
- To give opportunities for auditory, visual, motor and tactile development
- To give opportunities for expression and enjoyment

As there was a language barrier between myself and Maruf's mother, it was difficult for me to involve her in the process of setting aims, although I felt that they were compatible with her wishes as she had been involved with creating Maruf's personal learning plan (Maruf's teacher speaks the same language as her).

Progress towards aims

Opportunities for choice and control

In each music therapy session Maruf was given choices between different instruments. It was often hard to identify Maruf's choice, but having his parents present in sessions was very helpful as they were more able to identify his preferences. Each session began and ended with the same greeting or goodbye song to help Maruf understand the structure of the session. I repeated the same or similar activities each week, with the addition of one of two new instruments or activities from time to time. In session six I positioned Maruf in front of the piano for the first time and he seemed to particularly enjoy this instrument. He spent a long time playing the keys with very focused attention whilst smiling and vocalising. The piano became a feature of our sessions in subsequent weeks.

Use of the voice and enjoyment

On several occasions I used a particular technique to encourage Maruf to vocalise; I played the guitar, rocking back and forth between two chords to provide a stable, predictable structure, then imitated and developed Maruf's vocal sounds. This would lead to turn taking and musical conversations. On occasion, Maruf made a sad sound and matching facial expression. I replied with a similarly mournful, sympathetic 'oh-oh' sound Maruf smiled and I felt that he was showing he was pleased because I had recognized his mood and responded. I used vocal musical devices to build anticipation and excitement; on one occasion I sung 'Maruf Maruf Maruf', getting louder and rising in pitch before stopping dramatically. This made Maruf laugh and vocalise more himself.

Opportunities for development

On many occasions I placed a drum next to Maruf's hand. He then used either his hand or another instrument to play the drum. I waited to give him time to play, then responded to his playing in a similar way, for example if Maruf scratched his nails along the surface of the drum I would do likewise. This continued into a dialogue of many minutes' duration.

Conclusions

In each music therapy session Maruf had the opportunity to select and play different percussion instruments; some familiar, some new. I responded to his playing, vocalisations and body movements, developing them into dialogues. Maruf clearly showed his enjoyment of many aspects of the music therapy sessions, channeling physical effort to play instruments for sustained periods, vocalising frequently and often smiling.

Reflections from researcher diary

Language barrier

Maruf's mother and I did not share a language. This barrier to our communication was difficult at the beginning of the clinical work when I wished to set up the practicalities of her attending music therapy sessions, and discuss potential aims with her. Once the sessions got under way, however, and I was working in a largely non-verbal way with her non-verbal son, my intentions were clear to her and we shared an understanding.

Video consent

Maruf's parents had not given consent for me to video record Maruf's music therapy sessions. They had not given me a reason for this. Maruf's aunt attended one of his music therapy sessions alongside his mother, and at one point in the session took out her mobile phone and recorded Maruf and I playing together. I was surprised as I knew that they did not want me to video sessions, but as we did not have a common language I was not able to ask them about this, nor ask the aunt about her intended use of the video as it contained my image. I felt a moment of frustration but also felt I may have to accept that I might not find out the answers to these questions.

Missed sessions

Maruf did not attend his second and third music therapy sessions as he and his family travelled to Pakistan to attend the funeral of a relative. The school staff told me it is not uncommon for their pupils to have an extended absence following the death of a relative in a far away country.

5.2.5 Case study five: Tahir

Referral

Tahir was referred to music therapy session by his class teacher to give him opportunities for non-verbal interaction, expression of emotions, and to develop his communication skills.

Background

Tahir has autism spectrum disorder. He has very little verbal language, just a few words, but he makes a wide range of vocal sounds. He is able to walk, and often indicates his preferences by going to something he wants and touching it or picking it up.

Assessment

Tahir had two assessment sessions. He showed interest in the music and musical instruments, especially guitar and piano, smiling and moving his body rhythmically in response to music being played, and he played a number of the instruments available to him. He vocalized frequently during the session, seeming to use his vocal sounds as emphasizing a request or need. He spent only a short time on each activity or instrument, and indicated several times that he was hungry. Tahir's mother suggested the session time might not be helpful for Tahir, as by late morning he has been awake for some time and is tired, and also hungry as it is approaching lunchtime.

Aims

Aims for the music therapy sessions were as follows:

- To develop elements of communication through music such as turn-taking and listening

- To give Tahir opportunities to communicate and express himself through improvised music-making
- To promote use of the voice

Progress towards aims

Turn taking and listening

Tahir showed interest in the different musical instruments and often played them. When he started playing I would also begin to play, sometimes waiting for him to stop before playing something relating to what he had just played, then stopping and waiting for a reply. We had many similar dialogues. As time went on, I felt that we were better at having these conversations with each other; I felt that Tahir knew I was responding to him when I played, and waiting for him to play again. Sometimes if I stopped playing he would encourage me to play again by playing his instrument.

Communication and expression

During music therapy sessions I would often begin to interact with Tahir by observing his actions and his body language, where his attention lay and take this as the starting point. For example, I noticed that he was looking out of the window, and began a simple song about this, matching the style of the music to his calm and reflective outlook. When he diverted his attention into the room I changed the song accordingly. I left lots of spaces and silences for Tahir to play, and tried to reflect his changing moods and reactions in my playing. This approach emulates the patterns of relating in early mother–infant interaction, and helps with the development of communication as well as building up a trusting relationship. As time went on, Tahir and I had a number of musical interactions in which he would play instruments and show enjoyment or excitement through the music.

Vocalisation

Tahir used his voice frequently in music therapy sessions, and I encouraged this through imitating Tahir's sounds, and attempting to draw him in to musical vocal dialogues. I would respond to the musical qualities of the sounds, following Tahir's pitches, rhythms and tone quality, as well as the emotional content. I would often support these exchanges with an accompanying instrument to provide rhythmic and or harmonic structure and increase the aesthetic quality of the exchange, motivating Tahir to continue.

We also explored the amount of structure and freedom or choice present in music therapy sessions. I was keen to allow Tahir plenty of opportunities to make choices and take control during the session, but also to provide a supportive structure. At times Tahir seemed distracted or unfocussed in sessions and in discussion after sessions with his mother we decided it might be due to the number of instruments in the room, so reduced the number available in sessions. We also changed the session time to first thing in the morning, and although Tahir did sometimes indicate he was hungry or thirsty, on the whole he seemed more focused in sessions.

Conclusions

Music therapy sessions have given Tahir opportunities for exploring different means of communication through a non-verbal medium, and in music, one that interests and motivates him. Tahir has a strong character and does not participate in activities in which he is not interested, but through music and musical instruments he can be drawn into interactions. This is most effective when the songs or activities reflect something he is interested in, or contain elements of humour, for example funny sounds or exaggerated gesture.

Reflections from researcher diary

Languages

Tahir made a wide range of vocal sounds. Sometimes these utterances sounded as if he was babbling or trying out different phonemes, like a young child exploring language without yet making words. On one occasion in particular, however, he made a particular sound many times over and over again. I had a feeling this was a non-English word rather than a random sound, and as he spoke and/or understood another language in his home, this was possible. Had his mother attended that particular session I could have asked her for the significance of the word/sound, just as on another occasion she was able to translate a sign Tahir made as 'thirsty', but unfortunately she was not able to come to the session that week.

5.2.6 Case Study six: Saeed

Referral

Saeed was referred to music therapy to give him opportunities for different sensory experiences, and one to one interaction.

Background

Saeed has profound and multiple learning disabilities, including significant visual and hearing impairments (for which he wears hearing aids), and has epilepsy. His classroom teacher is working with him to help him anticipate events using tactile cues, to explore a range of sensory materials and consistently reach for a preferred object from a choice of two with verbal prompts.

Assessment

Saeed had four assessment sessions. In each session I sang a greeting song to him and then played instruments, and offered him a range of musical instruments to play.

On a few occasions he repeatedly withdrew his hands after they had been placed on an instrument. On one occasion he became very animated at the sound of the flute, moving his body and vocalising. In three out of the four sessions Saeed appeared very tired; the classroom assistant present in the session said this may be because he had been swimming that morning. After this his teacher swapped his swimming to a different day and Saeed then seemed to have more energy during music therapy sessions.

Aims

After discussion with his teacher, and with reference to his Individual Education Plan (IEP), the following aims were decided upon for Saeed's music therapy sessions:

- To provide opportunities for Saeed to hear and play a variety of different musical instruments with different timbres and ranges of sound
- To encourage vocalisation as a means of interaction
- To give Saeed opportunities for choice and control

Progress towards aims

Variety of instruments

I brought a selection of instruments to each session for Saeed to hear or play; percussion, melody and harmony instruments of varying pitches, timbres, and textures. Saeed often appeared more animated when he heard the sound of the flute, vocalising and moving his arms. On a few occasions I placed a djembe (tall African drum) leaning it against Saeed's legs, and placing his hands on the skin of the drum so he could feel the vibrations. After playing a rhythm myself for a short time to encourage Saeed to play, he scratched the skin of the drum. When he stopped, I imitated his scratching then waited. He scratched the skin again. This dialogue continued for several minutes. Some of the instruments available to Saeed

were large and made a lot of noise when played. This included the ocean drum, which he played by pushing it away or tapping on the drum skin.

Vocalisation

Saeed often vocalised in music therapy sessions. I encouraged his vocal sounds by vocalising myself, imitating and developing the sounds he made and sometimes creating a musical structure around our vocalising using usually either the guitar, the flute or a drum. Saeed often vocalised in tune with the instrument being played (if it was a melody instrument).

Control

By following Saeed's movements with my playing, and creating supporting musical structures around his movements and vocalisations, I was able to give him opportunities to be in control of the music, and his environment. Although it was difficult to tell at times to what extent he was aware I was following him, he would often continue with the movement I was following for some time. He sometimes blinked in time with each note played when we were playing particularly slow, quiet music.

Conclusion

Through music therapy sessions, Saeed had opportunities to interact with the music therapist vocally and using a range of musical instruments. On several occasions, Saeed had musical dialogues with the music therapist. Listening, waiting and responding form the basis of communication, and were a central part of music therapy sessions. Saeed was able to control the music through his body movements and vocalisations.

Reflections from researcher diary

I did not make any comments relating to the research topic as such. My main reflections upon working with Saeed were around the fact that he was one of the hardest to reach children with whom I have ever tried to engage as a music therapist, due to his profound disability. He responded very little in relation to other children I had worked with, and as I saw him only 16 times, there was not much time to learn about him and how he interacts with the world. Additionally, in those sessions when one of his parents was not present, I was not confident that his hearing aids were working correctly. The barriers between Saeed and I were not primarily to do with language or culture, but with his very significant level of disability.

5.2.7 Case study seven: Bartosz

Referral

Bartosz was referred for music therapy by his school to give him a means of expression and a creative outlet. It was also felt that he would benefit from having a new experience and building a relationship with a new person.

Background

Bartosz has autism spectrum disorder. He speaks in short sentences, sometimes in English, and sometimes interspersed with, or entirely in Polish. He is most comfortable in fixed, comfortable routines and struggles to try new things, or when those routines are broken.

Assessment

Bartosz had two assessment sessions. I began both sessions by singing a hello song. Bartosz seemed to enjoy this and was then interested in playing the guitar, which he played for several minutes. I invited him to choose from the instruments available. He picked several of them up and tried them briefly. In the second session,

Bartosz was enthusiastic when I suggested we make up a musical story, and supplied characters and a plot while I accompanied with the guitar and singing. Both times, however, he wanted to finish the session early and seemed a little anxious.

Aims

- To provide Bartosz with a means of expressing himself and being creative, through playing musical instruments
- To form a relationship with the therapist in one-to-one music therapy sessions through shared musical interaction
- To promote creativity and confidence
- To develop concentration and focus on an activity

Progress towards aims

Self-expression and creativity

Bartosz often requested songs he wished me to sing and play on guitar while he played the drum. He also liked to make up musical stories, and have me sing songs about him. His playing, which had initially been quiet and for short durations of time, became more varied, often loud and energetic. I tried to respond to both his verbal requests (e.g. song choice) and the non-verbal elements of his communication, matching my music to his playing and his body movements as a way of showing him that I was responding to him.

Relationship and interaction

Initially, Bartosz seemed anxious in music therapy sessions, and often wanted to finish the session early, or go to the corner of the room to look at a book. As time went on, Bartosz became more comfortable in music therapy sessions, and often wanted to keep playing music after the end of the session time. He no longer

seemed anxious in the sessions, and was happy to play instruments for longer durations. The sessions had a familiar but flexible structure, beginning and ending with the same hello/goodbye song, but with a variety of musical activities in between, and Bartosz had freedom to choose instruments and activities during the session.

Confidence and focus

In early sessions, Bartosz often complained that the music was too loud, that it was giving him a headache. The music and the sessions felt restricted, as Bartosz would only allow a very short amount of playing before he stopped us. Over time, he gradually allowed his own and my playing to become louder, until he was happy playing loudly and freely on the drum for much longer periods of time.

Conclusion

Over the 20 week period in which Bartosz had music therapy sessions, he became confident in playing musical instruments with the music therapist, making choices and using music to express different emotions, from quiet, gentle playing to exuberant, loud playing. He became musically more flexible as the time went on, gradually starting to play more loudly, and trying out a greater range of instruments as well as playing for longer durations.

Reflections from researcher diary

Language

Bartosz talked often during the sessions, seemingly more to himself than to me, although sometimes this commentary was directed at me. He spoke in both English and Polish, and as I do not speak Polish I was not able to understand these comments. When his mother was in the music therapy session with us she was able to translate the Polish words into English for me; on one occasion he said ‘headache’ with a grimace, indicating he was finding the music too loud. I felt somewhat helpless

in that I was unable to understand his attempts at communication, and found it interesting that he expected me to understand Polish; I wondered if he speaks in Polish to everyone he meets.

Bartosz's English comprehension, however, did seem to be good. He often seemed anxious and wanted the session to end but when I explained to him what was happening, 'now we're going to take turns choosing instruments to play', or asking him how he'd like the music to sound, 'How would you like me to play the hello song? Loud or quiet, fast or slow?' he was calmer. Having a shared language greatly helped us to negotiate anxious moments and give Bartosz a measure of control.

Religion

Bartosz's family were practicing Roman Catholics and Bartosz regularly attended religious services. This was an important part of his life and in music therapy sessions he sometimes wanted to sing songs with a religious theme, for example, the Christmas song 'Little Donkey'; Bartosz would request 'Donkey', then ask for verses about 'Mary', 'Jesus'. He also asked for songs about 'Jesus on the cross', and as I wasn't aware of a particular song he was referring to I improvised a song using his words.

I reflected in my researcher diary and in supervision that I would not always feel comfortable incorporating religious figures into music within a music therapy session due to concerns about causing unintentional offence through seeming to appear disrespectful. In Bartosz's case I happened to share his religion so did not have quite the same concerns, although I could not assume that using religious imagery in the music therapy session would be acceptable to Bartosz's family. My supervisor felt that I might be trying to be too sensitive around this point; I think religious difference

can be a difficult area and some people (including myself in this instance) can have an exaggerated fear of causing offence.

5.2.8 Case study eight: Aryan

Referral

Aryan was referred for music therapy to give him the opportunity for positive experiences of interaction, as he exhibits behaviours that challenge others, and an environment in which he can initiate interaction; his class teacher had noticed that he often received interaction of different types from others, but rarely reached out to others himself.

Background

Aryan has autism spectrum disorder and limited mobility; he can move around by bottom-shuffling whilst seated on the ground, or walking very unsteadily. He has no language, but seems to understand some words.

Assessment

Aryan had two assessment sessions. I began the first assessment session by singing a greeting song to Aryan while he sat on a plastic chair. He seemed to listen to the song, showing interest in the guitar and the music. I offered him different instruments to play. He played the thunder drum for a long time, but seemed restless and tried to get out of his chair on several occasions. For the second session, Aryan's classroom assistant and I planned that he would spend the session on the floor, and I prepared the room accordingly, tidying the furniture and scattering instruments around the room for Aryan to find and play, with the intention that this would be an environment where nothing was forbidden and anything he picked up could be a springboard to interaction. This seemed to work better; Aryan seemed much happier, and played with many of the instruments.

Aims

Following the two assessment sessions and discussion with Aryan's teacher, the following aims were decided upon:

- To provide a positive experience of interaction, primarily through non-verbal musical improvisation
- To provide an environment in which Aryan can initiate interaction, and initiate choice of musical instruments
- To give Aryan an opportunity to express his emotions through playing musical instruments and vocalizing, and have those emotions recognised through musical interactions.

Progress towards aims

Positive experience of interaction

The music therapy room was laid out so that Aryan would safely be able to explore the room and the instruments without needing to be restricted to a large extent. Therefore, the interactions that resulted were not attached to asking him to stop doing something or restricting his moving, but joining him in playing musical instruments.

To give an example of this, at the beginning of a session I sing the hello song while Aryan sits quietly and listens. We then share the guitar. I leave plenty of spaces for him to play. I respond to him in my playing; at one point he becomes very quiet, so I do likewise. After he strums the guitar I do a vocal trill, and this funny sound makes him laugh. He becomes interested in my arm so I use it to bring his focus back to the instrument. I relate this kind of listening, interacting and exploring to mother-infant interaction, and Stern's affect attunement.

Initiating interaction

Following the assessment period, the music therapy room was laid out so Aryan was free to move around, and find and play musical instruments, which were scattered around the room. Aryan seemed to enjoy playing the musical instruments and so was motivated to use them. He also appeared to especially enjoy the guitar when played rhythmically and energetically. This meant he could choose a musical instrument, and then when he played it and I joined him, the music motivated him to continue. I tried to allow him space, waiting for him to come to me.

On one occasion Aryan and I started out far apart in the room. I played the flute. Aryan came over and indicated he would like me to play the guitar instead. I did so and his smiling face seemed to show that I had correctly interpreted his wishes. In this moment he was able to come to me and affect my behaviour; I was able to understand his wishes, and this all took place within a relaxed, happy exchange.

Sharing emotions

In music therapy sessions I tried to match Aryan's affect or apparent emotional state through the characteristics of the music I was playing, my vocalisations, facial expressions and body language. Aryan seemed to respond to this, often laughing or smiling when I had correctly identified something in him.

Conclusion

Over the twenty week period Aryan and I developed a relationship based on listening, and playing music together. The set-up of the music therapy room was designed so that Aryan had freedom to move around, and within that, freedom to initiate interaction, which he did. This freedom also meant that the interactions in music therapy sessions had a positive focus; he did not often have to be restricted.

Through musical interactions Aryan and I were able to communicate emotions and also to have fun.

Reflections from researcher diary

My work with Aryan was mainly focused on non-verbal interaction oriented in theories of early infant-caregiver interaction, especially those of Daniel Stern. Our dialogues seemed to be in a very early place, of motherese and the universal first language of an infant and their carer. I did use speech when I was with Aryan, but I felt he responded not to the words but the tone and context which he understood clearly.

5.3 Relating findings from case studies to research questions

The research questions will now be reviewed in light of the information gathered from the case studies. This set of case studies involving music therapy with children from minority ethnic backgrounds enabled the researcher to have a close look at the experience of intercultural work for the purpose of research, including the researcher's own personal responses.

Main research question

- What factors does a music therapist need to consider when working with a child from a cultural background other than her own?

Sub-questions

- How do culturally informed perceptions about the function of music affect music therapy work?
- Music has links with cultural identity: How does this relate to music therapy practice?

5.3.1 Main research question

This question explores how and whether a music therapist should adapt their practice when working with a child whom they identify as having a different cultural background to them. The case studies, generated as they were from clinical notes, reports and the researcher diary, give the music therapist's perspective. I had personal responses to some of the issues raised, that relate to my own cultural background. I have tried to be frank about these in line with my chosen methodological approach in which the researcher's own subjectivity is acknowledged and may inform the results.

Language

Linguistic ability and use of languages other than English was a theme that came up across several of the case studies. Bartosz and Tahir both spoke in fragments of languages I did not understand. I felt that I was letting them down in a way by failing to understand them when they were making efforts to communicate, but this could not be helped; it would not be possible for me to learn the languages of all the children I see in music therapy. On the occasions when their parents were there they were able to translate (both verbal language and sign language). This created another layer of interesting dynamics between the parents and myself as they were supporting me to communicate with their child, whereas in my professional role I would usually think of myself as an expert in communication.

With these same children, Bartosz and Tahir, and their parents, I reflected on how useful it is to have a shared language to support the children in understanding the music therapy session, and to be able to talk to the parents about their child and through this, better adapt music therapy sessions to their needs.

Culturally based assumptions

Discussion was not at all possible with Maruf's mother, due to our lack of shared language. This included an issue I would have liked to have better understood; Maruf's mother did not extend her consent for her son's music therapy sessions to be video recorded. Another family had decided not to take part in the research project citing objections to video recording due to their Muslim faith (although I did tell them video recording was not a requirement for participation in the project). I wondered if this might be the reason why Maruf's mother had declined consent too, until Maruf's aunt, present in one music therapy, took out her phone and videoed Maruf. I had made an incorrect assumption based on their cultural background, and unfortunately was not able to find out the true reason much later; in the interview Maruf's mother explained she thought the video was for her and did not need another video of Maruf.

Baraq spent a lot of time in music therapy sessions controlling his mother; demanding she sat or stood in a certain place or played a particular instrument. From slight knowledge of some Muslim cultures and their different perspectives on gender roles I had a moment of speculating whether he saw males in his family act in a more dominant manner and was imitating this, but felt this was my own prejudice casting his behaviour in a cultural context without evidence. Many children try to control their parents without this necessarily connecting to their cultural background. My role in the clinical setting was to work with that individual relationship, so in some ways it was not important whether that behaviour was derived from cultural practices within the family or the particular dynamics of that relationship. As part of the reflexive research process, however, I tried to be very honest about my reflections.

Empowering parents

The music therapy sessions with Hameed were initially challenging for me because the parents were so enthusiastic and involved in every moment that it was difficult for

me to have much influence and demonstrate my approach. Over time, however, the parents began to understand what I was trying to achieve and leave more space for Hameed to initiate contact and respond. When working with parents in sessions I tried to demonstrate my approach without 'correcting' or undermining them. This could be considered particularly important for parents from ethnic minority backgrounds who may already experience being marginalized and disempowered by the systems around them.

Working in the family home

Saif's music therapy sessions took place in his home. As it was a Muslim household I had a little knowledge of what to expect, for example that I should take my shoes off before entering the house. I was also entering into their family culture, and certain therapeutic boundaries that I would have upheld in the school had to be more flexible. Saif's parents left his bedroom door open, and I felt this was a precedent I shouldn't break, even though elsewhere I would have preferred to keep it shut. Also, we had a number of visitors to our music therapy sessions. Again, I felt that it was not right for me to challenge this. All the visitors were close family members and I did not feel that their presence compromised the safe space I was trying to create, as we and they were already in the safe space of the family home. I felt my flexibility with boundaries was necessary to maintain a good relationship with the family as it may have been hard for them to accept being restricted in their own home and separated from their son.

Extended holidays

During the course of the 20 weeks of music therapy, Maruf missed two weeks of school because he had gone to Pakistan with his family to attend the funeral of a member of his extended family. Another child who I had considered to take part in this research was excluded as he went to Pakistan for two months for a similar

reason. Both schools said that extended absences of pupils with familial ties in other countries was an issue for them. This is, of course, not something music therapists can anticipate in the children they see, but it is perhaps worth understanding.

The barrier of disability

When working with Saeed in particular, I felt that the overwhelming barrier that separated us, and that I worked so hard to overcome, was his profound level of disability. Other factors could have come between us in music therapy sessions, but his disability provided an almost insurmountable obstacle that eclipsed anything else, in a way that cultural barriers did not in my work with the other children.

5.3.2 Sub questions

How do culturally informed perceptions about the function of music affect music therapy work?

Cross-cultural aspects of music therapy approach

With many of the subjects, but especially with Aryan, I reflected that many of our interactions in music therapy sessions were very closely related to the interactions between infant and caregiver; largely vocal conversations of varying sound, pitch, duration and tempo that related so closely to music, but are a universally observed phenomenon between parents or carers and their babies. For this reason I felt that the parents were able to intuitively understand my interactions with their child, because they were similar to the kinds of early conversations they had instinctively been having with their children themselves. Even if the parents had not (as is likely) understood what kinds of music would occur in music therapy sessions, because they and their children had had virtually no exposure to music therapy before their involvement in the research project, they quickly understood once they had observed them.

Music has links with cultural identity: How does this relate to music therapy practice?

Multicultural musical knowledge

An individual develops and lives within a system of cultural influences that influence the music to which they are exposed. This includes music therapists. One of my first reflections upon visiting Saif in his bedroom at home, with a Bollywood film playing on his TV, was that he was exposed to a wide range of musics, including the music of south Asia, the vocal style of Islamic prayer, and music played in wider society in his town in the north of England with Western influences. My reflection was that his musical vocabulary was grounded in two continents while mine related to my upbringing in the UK alone and in this respect he had a much greater musical knowledge than I did.

Religious influence

Bartosz's musical preferences, rooted in his Polish Catholic background included religious music and music featuring religious figures from his tradition. I felt the need to reflect on how I should be incorporating his wishes into music therapy sessions. Was it enough for me to be led by him, or was it possible that such inclusions into the music might be deemed disrespectful by his family? I was fairly sure there was no risk in this instance, but could there be cases when a music therapist would be advised to avoid references to religion despite a request from a child? Over-cautiousness, cultural generalizations, or fear of causing offence could, however, could cost an opportunity for effective engagement with a child.

5.4 Conclusion

When working with a person in music therapy I try to put assumptions or pre-conceptions to one side and respond genuinely to that individual. I cannot avoid, however, the fact that I am a product of my culture and upbringing, and have both conscious and unconscious knowledge and biases. This can sometimes help me in

my work, but it may also cause barriers I am not aware of. Through this research, and particularly these research case studies I had the opportunity to really reflect on how culture, both the children's and my own, has woven its way through the relationships that developed through the music therapy sessions.
I became aware of some of my own assumptions and stereotypical views, but also really appreciated this opportunity to think in greater depth about these children's wider experiences, and how they may or may not relate to our music therapy relationship.

Wider areas for consideration that emerged were the presence of language barriers, how useful a shared language can be, but also the non-verbal aspects of music therapy rooted in early infant interaction that have universal qualities which can be understood without language. Working in the family home presented particular challenges to the therapist's use of boundaries, and an understanding of cultural customs was useful, but gave insight into the child's experience outside music therapy. A sensitive approach can empower parents and support them in interacting with their child. Disability can be the most significant barrier far beyond cultural difference.

From my experiences in compiling these research case studies and examining them through the research questions, I consider that a thoughtful, reflective approach with continual openness to the possibility of cultural factors influencing music therapy work is required. This awareness should include that of relying on assumptions, and gaining cultural knowledge if necessary, but always starting with the individual and which are the barriers to them leading as full a life as possible.

Chapter six

Parent interviews

6.1 Introduction

This chapter contains the data from the analysis of the interviews with parents. The methodology is summarised, then the procedure of devising the interview schedules to support the semi-structured interviews is described. The process of analysing the interview transcripts using an adapted version of Interpretative Phenomenological Analysis is described, and the tables of results are displayed. Reflections and conclusions from these results are made.

6.1.1 Summary of Methodology

As described in chapter two, which outlines in much greater detail the rationale for the methodological approach, phenomenology 'a philosophy that is concerned with the question of how individuals make sense of the world around them and how in particular the philosopher should bracket out preconceptions concerning his or her grasp of the world' (Bryman 2008 p. 697). Interpretative Phenomenological Analysis (IPA) is a research technique based in phenomenology that involves drawing data from (usually) semi-structured interviews by transcribing them then putting them through a systematic, qualitative analysis (Smith, Flowers and Larkin, 2009, p.4). This is the method of analysis adopted for the purpose drawing out key themes from the parent interviews in order to answer the research questions.

Semi-structured interviews were administered by the research assistant, following construction of an interview schedule. An interview schedule is a more flexible version of a questionnaire, allowing the interview to follow the flow of conversation and explore subjects in greater detail where appropriate. Recordings of the

interviews were transcribed and the IPA method was applied, resulting in the tables of themes and superordinate themes displayed below.

6.1.2 Creating the interview schedule and administering the interviews

As recommended in the method outlined by Smith, Flowers and Larkin (2009, p.61) the main research question and two sub-questions were the starting point for creating the interview schedule. After reflecting on how the parents of the subjects might provide answers to the research questions, I broke down the questions into the key themes relevant to the parents. I was aware that these interviews would only partly address the research questions because to an extent those questions were about how cultural issues would affect music therapists. The interviews would only provide the parents' perspective.

Main research question and key themes relating to parents

What factors does a music therapist need to consider when working with a child from a cultural background other than her own?

Key themes relating to parent:

- Questions around the child's experience (through the eyes of the parent); preferences in e.g. music, pastimes
- Questions around information on cultural background: ethnicity, language, family,

Sub-question one and key themes relating to parents

How do culturally informed perceptions about the function of music affect music therapy work?

Key themes relating to parent:

- Questions around music in parent's culture
- Questions around parent's experience of music in healing/therapy

Sub question two and key themes relating to parents

Music has links with cultural identity: how does this relate to music therapy practice?

Key themes relating to parent:

- Questions around cultural identity and music
- Questions around their experience of and opinion on the music therapy process

Each of the six arrowed points above were grouped into four main areas of questioning, and then a number of questions within each area were devised, along with follow-up questions and probes to assist the research assistant administering the questionnaire. The four main areas were:

- Cultural/ethnic identity of the family, including social contacts and music within family and social life
- Music Therapy; the parents' experience of music therapy, the music therapist and the instruments used
- Home life; exploring the sounds, music and language in the child's home life
- Involvement in the research project; a short section exploring the parents' thought on being involved in this research

Through reflecting on how the research questions related to the parents I developed the six key themes outlined above, which were then grouped into four main areas of questioning. The following table shows how this process evolved:

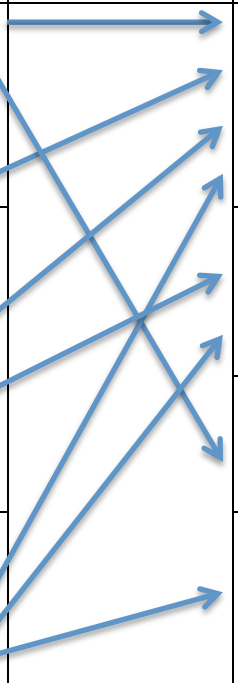
Research question	**Key themes**		**Areas of questioning**
Main Research Question *(What does a music therapist need to consider when working interculturally?)*	Child's experience at home Cultural background of family		Cultural/ethnic identity of the family, including social contacts and music within family life
Sub-question one *(Culturally informed perceptions about the function of music)*	Music in parent's culture Parent's experience of music in healing/therapy		Music therapy; parents' experience, music therapist and instruments Home life; sounds, music and language
Sub question two *(Music's links with cultural identity)*	Cultural identity and music Experience of music therapy process		Involvement in research project

Table 1: Process of developing interview schedule from research questions.

The questions in each of the four main areas were generally asked in the order in which they are shown above unless a parent brought up a particular subject, in which case the interviewer would follow their lead. Smith, Flowers and Larkin (2009, p. 61) recommend beginning an interview with straightforward questions to help relax the participant and make them feel comfortable in what is often an unfamiliar situation. The questions around the cultural background and family structure in the first section seek mainly factual answers and do not require much consideration. The research assistant was free, however, to move between sections, following the flow of conversation and returning to any gaps in the schedule later. She was also briefed on the focus of the research and the desired outcomes of the interviews so was able to further explore comments from parents that might relate to the research questions. Additionally, the research assistant was given training in administering the interview schedule. She had previous experience of assisting research projects, and some

knowledge of the music therapy approach; she was asked to read some materials on administering semi-structured interviews (Smith Flowers and Larkin p. 64-73), and she practiced interviewing a volunteer before she met the parents. This gave her the chance to further familiarise herself with the interview schedule and identify any areas she wished to clarify with me before beginning the interviews.

The interview schedule in its entirety may be found in Appendix 7, but below is an example of part of the schedule showing the topic 'Home life'.

Issue/Topic	Possible Questions	Possible follow up questions	Probes
Home life	What are the sounds you might find in your house? Which languages do you speak Some questions about your son (who has been attending MT) How do you interact with your child?	Music played, radio, TV, DVDs? Any other music, dance, film? With whom do you use these languages? What languages do you speak with him? What does he listen to/watch at home? Talking? Singing songs? Games?	Could you give examples? Could you say more about that? How has that come about? And…?

Table 2 Example of interview schedule: 'Home life' section

The questions within the interview schedule were composed using guidelines from Smith, Flowers and Larkin (p.59) Open questions were adopted to prompt more in depth answers. The questions were also composed using relatively clear, simple language, bearing in mind the parents were responding in their second or third language or via an interpreter.

Conducting the interviews

At the final music therapy session for each child, I verbally arranged the parent's attendance at an interview, explaining what would happen, how long it would take and that it would be audio-recorded. The parents at each of the two schools were invited by letter to attend their interview at a particular time and date, typically at a similar time to when they had attended their child's music therapy session.

Creating the transcriptions

The research assistant recorded the interviews using a portable recording device. She gave the recordings to me and I transferred them onto my computer, onto a programme for playing audio tracks. I created a Word document for each interview, then transcribed the interview as closely as possible, playing a few seconds of audio, typing the words into the document, but often having to listen to a section two or more times if the speech was difficult to hear. I deliberately included each utterance as closely as I could; each repeated word, sound and pause. Short pauses were indicated with a comma, longer pauses with […]. I used little punctuation, except when necessary to clarify the meaning, for example using commas to separate phrases. This was a very time consuming process which took several hours for each interview, varying slightly depending on the length of interview and ease with which I could hear the voices.

6.1.3 The adapted Interpretative Phenomenological Analysis approach used for this research

Interpretative Phenomenological Analysis (IPA) is a means of exploring the experience of participants via a subjective, but systematic analysis. The authors of this method, however, emphasise that rather than a rigid method, IPA is rather 'a set of common processes (e.g. moving from the particular to the shared, and from the descriptive to the interpretative) and principles (e.g. a commitment to an understanding of the participant's point of view, and a psychological focus on

meaning-making in particular contexts) which are applied flexibly according to the analytic task (Smith Flowers and Larkin, 2009, p. 79). The recommended approach for those new to IPA, such as myself, is to begin by adhering closely to the steps given in the method, before allowing to move between and around them as the data emerge; 'we would advise the novice embarking on an IPA study for the first time to begin by working closely with the suggested set of steps, and then to adapt them when and where they feel comfortable to do so, and the data require it' (Ibid, p. 81).

Below I outline the process I adopted based on the detailed steps provided in '*Interpretative Phenomenological Analysis: theory, method and research'* (Smith, Flowers and Larkin, 2009, p. 82-107).

Step one: Reading and re-reading the transcript

I typed up the transcripts myself rather than use a research assistant. This was time-consuming but was an important part of the process as it increased my familiarity with the interviews. Before proceeding with the analysis, I read the transcript several times and listened to the recording of the interview in order to try and immerse myself in the voice of each parent and get a sense of the emotional currents during the interview, and how the dialogue evolved. This process of familiarisation meant that during subsequent parts of the analysis I was still able to hear the parent's voice. Additionally, I had asked the research assistant to keep a diary, noting anything she had observed or felt about the interview that might be of interest. For example, her impressions of the way the parent engaged with the interview, as I would not be present in the room. These notes were read along with the transcript as another source of information about the subject and interview. Salient points from the research assistant diary can be found in the commentary below the results tables for each interview.

Step two: Initial noting

I annotated the interview transcript closely, highlighting aspects of the text in three main areas (Ibid. p. 84). An example is given below, and an annotated transcript may be found in Appendix 8. When writing comments on the text as demonstrated in table 6.2 below, the left column contains the transcript from the interview. The right hand column contains three types of comment; descriptive or factual comments are in normal type, linguistic comments are in italics and conceptual or interpretative comments are underlined. 'I' denotes 'Interviewer', and 'P' is parent.

- Descriptive comments on factual content of the text
- *Linguistic comments* highlighting use of language
- Conceptual/interpretative comments looking at underlying meaning

Interview transcript	**Notes**
I: And what did you think of Caroline as a therapist	
P: She's amazing, she's absolutely fantastic. She's very professional and down to earth and, erm, she's engaged with us and the, er, and [child]. She's asked our permission for everything from day one. Ahhhm, and I jumped at the chance	Complements professionalism of MT, personal style Appreciates being asked permission – respectful, professional attitude of MT *jumped – energy, enthusiasm for MT, for son*
I: Yeah	
P: Cos I know what my boy wants and…	He knows what his son needs
I: Yeah	
P: …needs	He fights for his child and his needs – he knows better than anyone Parent is expert

Table 3 Example of annotated interview transcript

Step three: developing emergent themes

The annotations were formed into a list of around 30-40 themes. Duplicate or similar annotations were combined, and the themes were then grouped with similar themes into a spider diagram. An example of one of the spider diagrams can be found below, and a larger, more legible version in Appendix 9.

The themes were each placed around circular theme nodes such as ‘home life’ and ‘music therapy’. The nodes relate closely to the original main topics from the interview schedule.

Figure 6. Spider diagram showing themes from interview with Saif’s father

Step four: searching for connections across emergent themes

Examination and reflection upon the spider diagram suggested links between themes across the diagram. I drew lines between linked (and contradictory) themes to group them into super-ordinate themes. For example, the following four themes from different parts of the interview seemed to be linked:

> ‘They had music therapy before: previous knowledge/experience’
> ‘Parent is expert, knows what child needs, fights for child, does everything for them’
> ‘Music therapist engaged with family and child’
> ‘Music therapist asked permission’

The spider diagram showing lines drawing related themes together is found below.

The different coloured lines relate to different themes:

Orange	Emotional elements to music therapy
Green	Communication and language
Red	Benefits of music therapy for parents
Blue	Parent is expert
Brown	Music and culture
Purple	Importance of relationship

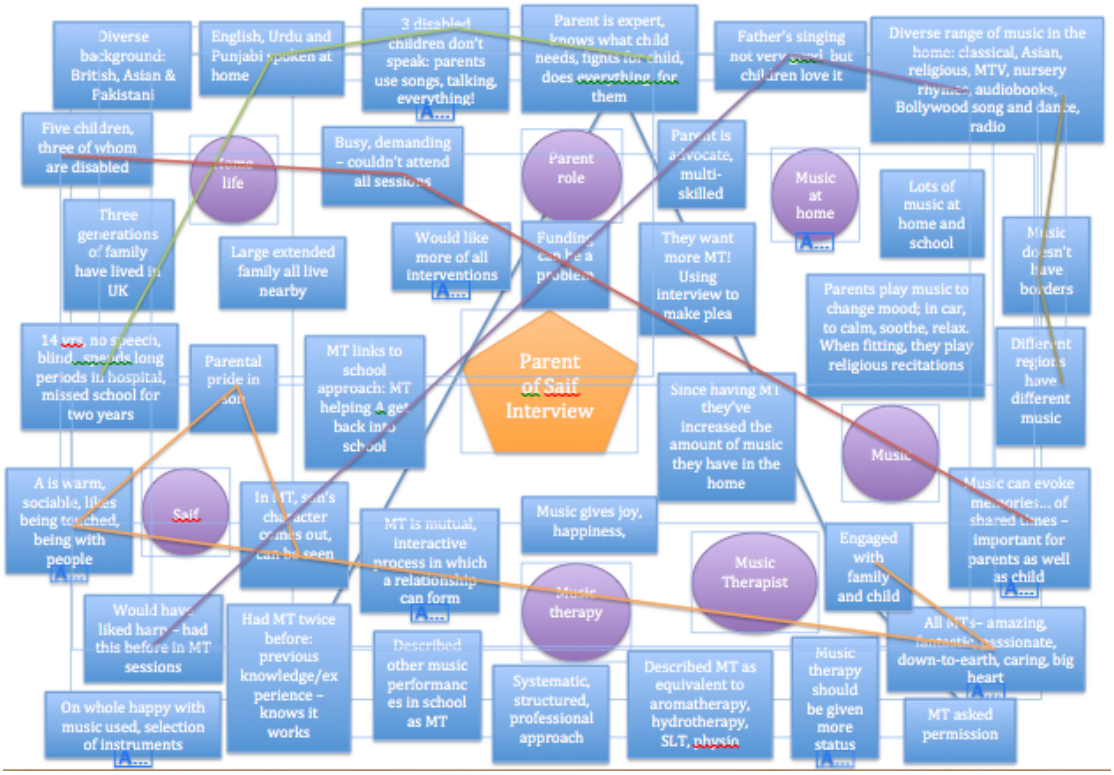


Figure 7. Spider diagram showing themes from interview with Saif's father with lines connecting themes (larger version in Appendix 9)

These four themes were then grouped into a super-ordinate theme 'Parent is expert'; the parent has unique knowledge of the child, is the expert on the child, wants to be treated as such but this is not always their experience.

Between three and five super-ordinate themes emerged from each set of interview data and will be looked at later in the chapter when looking at the data for each interview, then compared across interviews.

Step five: comparing themes across cases

Once each transcript had been analysed using steps one to four, a table was created to compare the superordinate themes of each parent, and whether themes recurred across one or more parents. This table may be found after the data tables for each family (table 4. page 161).

Comments on analytical process

As I became more proficient with the process, I combined or overlapped the steps. With each subsequent analysis I found myself getting a sense of themes and super-ordinate themes earlier in the process. In her research into carers' experiences in music therapy sessions, Keanampornpan comments on a similar evolution in her IPA process as she became increasingly more fluent in analysing the data, influenced by previous analyses (2015 p. 81). I endeavored, however, to also heed the exhortation to treat each new '…case on its own terms, to do justice to its own individuality' (Smith, Flowers and Larkin, 2009, p. 100).

I felt the linguistic analysis of the transcript; annotating use of language; was potentially more complex with my group of subjects as for many of them English was their second or third language. While all of the parents (apart from the two who requested an interpreter) were very proficient in English and able to engage with the semi-structured interviews, nevertheless I felt some parents struggled to find the word they wanted, or used similar words and phrases many more times than a native speaker would, due to their understandably more limited vocabulary. Choosing to repeat a particular word of phrase several times when one has a broad range of vocabulary to draw on could be interpreted as an intentional emphasis. During the analysis I tried to remain aware my subjects were not first language English speakers when annotating language.

6.2 Results of Interpretative Phenomenological Analysis of interviews

Below are the results tables of superordinate themes, themes and lines from the transcript for each parent, preceded by a short description of the child/family and followed by discussion of the unique features of each interview. Where relevant, comments from the research assistant's diary are also included where they add further information about the interviews.

6.2.1 Interview one: Saif's father

Saif has global development delay, visual impairment and no verbal language. Music therapy sessions took place at Saif's home and therapy aims included encouraging interaction through vocalising, and use of the hands and voice, as well as providing new sensory experiences through instruments and sound, and a new relationship with the music therapist. Saif's father and mother work full time as carers for Saif and two of his siblings who also have disabilities.

Superordinate theme: Communication/language

Theme	Transcript	Line from transcript
Saif and two of his siblings have no speech	*'[Saif] can't talk, nor can [sibling 1] [or sibling 2], so they babble or cry and the other two speak in English'*	363-364
Three languages used in the house	*'Urdu, Punjabi, mostly English'*	353
Parent is advocate, speaks for his child	*'I'm fully committed to my children, to advocate for everything'*	375-376

Superordinate theme: Parent as expert

Theme	Transcript	Line from transcript
The parent knows what the child needs, fights for them, does everything for them	*'I know what my boy wants and…needs'* *'I'm his father, I'm his advocate'*	222-224
The parent knows what music therapy is, had it twice previously	*'[Saif] has had music therapy before in hospital'* *'We were quite familiar with what the offer was' [music therapy]*	91-92 94-95

	'I know about music therapy we've worked with music therapists in the past'	164-165
Appreciated the music therapist gaining consent from him	*'She's asked our permission for everything from day one'*	218-219

Superordinate theme: Parent needs support/ challenges of being parent to a disabled child

Theme	**Transcript**	**Line from transcript**
Three of his five children are disabled	*'Two that are able… and three disabled children'*	80-88
The parents have a busy, demanding life	*'The logistics of having three disabled children… every bit of time you get to yourself you want to just…*	400-402
Sharing good musical memories and moments is important for the parents too	*'[Music] just takes your mind, takes you away somewhere pleasant and nice… it's memories as well, for happy times, parties… So it's massive… it's really important for him and for us'*	126-138

Superordinate theme: Importance of relationship/music/instruments

Theme	**Transcript**	**Line from transcript**
Comment that harp would have been good in sessions – the instrument makes the difference? The children love their father's singing – the relationship makes the difference	*'Brilliant… yeah the only thing I would say is that [Saif] likes the harp'*	192-193
They select music depending on Saif's mood; if he is fitting they play religious recitations	*[we choose music depending on] 'how he is. So like there's so many music channels on the TV now from MTV to all sorts. There's a wide selection so it's not just one genre there's so many different… so it all depends on how he is… ahm if he's fitting then we, we'll play, erm, the Qu'ran. We've got that an a CD, that's our bible for Muslims, and then the Qu'ran's recited'*	332-338

Superordinate theme: Complexity of considering music and culture

Theme	Transcript	Line from transcript
Music is universal, but specific to different regions/cultures	*'Music, erm, doesn't have any borders, erm it's different music for different countries, different areas, but it doesn't really have any…. You know like you asked me my, er ethnicity and my background… music doesn't have that'*	101-105
Saif has exposure to broad range of music	*'[Saif] listens to a wide range of music… from Western to south Asian to everything'*	108-110
At home they listen to a diverse range; Western classical, pop, nursery rhymes, audiobooks; Asian Bollywood, religious/Qu'ranic recitation	*[They listen to] 'Classical, Asian channels, classic fm, erm radio one'* *'So we've got different things, we've got nursery rhymes, we've got books with, er, CDs'*	317-318 339-341

Superordinate theme: Emotion and personality in MT

Theme	Transcript	Line from transcript
A has warm, sociable character Father is proud of his son – wants others to get to know him In MT sessions, his character and qualities can be seen MTs are have personal qualities important to the work; passionate, caring, big-hearted, down-to-earth MT made effort to engage with family and child	*'He's a lovely boy I don't know if you've seen the videos'* *'It takes someone very caring and very passionate to do music therapy with disabled children… [she's] very kind inside and having a big heart'*	149-150 229-234

Saif's father described in this interview his role as advocate for his child and his status as expert on his child's needs. He appreciated the music therapist's approach of listening to his opinions throughout the period of Saif's music therapy, including

the process of gaining consent for participation at the beginning of their involvement in the research project.

He spoke of how much all the family enjoys music; they play music on family trips in the car so it has an association with times spent as a family having fun, Saif likes to listen to Bollywood music via the television in his room, they play recorded religious chanting/prayers accompanied by instruments when Saif has fits. They felt these sounds calm him, and I felt in addition the parents also gained spiritual support. Saif's father also spoke of how he uses music himself for escapism, and the paradox that all the world has music, but it is different all over the world.

Saif's father acknowledged the human qualities, especially warmth, kindness and gentleness, that he saw in the music therapist, and that the music therapist was also able to see in his son. This was possible through my taking time with Saif, really listening to him, and engaging with him in a way that was meaningful to him.

6.2.2 Interview two: Baraq's mother

Baraq has a diagnosis of autism spectrum disorder. He uses just a few words to communicate. He seems a cheerful boy who was interested in wandering around the room exploring the instruments in the music therapy sessions but had a short attention span. Along with trying to extend his concentration span, music therapy aims were to develop his communicative abilities such as turn-taking and listening, and also to give him a means of exploring different emotions.

Superordinate theme: Keeping traditions

Theme	**Transcript**	**Line from transcript**
Parent values maintaining links with Pakistani	*'We go to Pakistan every year, second year, you know summer holidays…'* *'Yeah!' [emphatic – in response to question about whether she feels like she kept a lot*	148-149 106

culture	*of tradition from Pakistan in her home]*	
Important for Baraq to experience Pakistani culture first-hand	*'It's lovely for [my son]… it's totally different when we go there [to Pakistani village]… they get that side of everything, as well as here as well'* *that'*	160-169
Maintaining language as part of culture	*'All the kids talk a lot in English, but I'm trying to get them to talk more in our language so they don't lose that'*	259-260

Superordinate theme: Individuality within culture

Theme	**Transcript**	**Line from transcript**
Personal taste comes before culture	*'Whatever culture you come from, you're gonna bring your own kinda music and things'* *'It depends on the child…it doesn't matter what culture or background they come from, if you find out about the child, what kind of music and things they listen to or what… it's different for every child'*	35-36 20-22
A music therapist should consider personal taste first, then music from the cultural background	*'they might listen to English music or they might listen to… their own kind of cultural music, but you'd have to find out about each individual first to see what kind of things and incorporate that then in what you're doing'*	25-28
Siblings each have own musical taste and make choices about what they listen to	*'My youngest daughter at the moment she loves Frozen… with my daughter, er older daughter, she's er, eleven, and with her it's both. She listens to English songs as well as Asian ones. And then with my son he's… he listens to a lot of the Bollywood ones'* *'Everyone uses YouTube so they can pick just what they [want]'*	233-241 247

Superordinate theme: Music therapy is beneficial

Theme	**Transcript**	**Line from transcript**
Enjoyment in music therapy sessions	*'The sessions were brilliant, he loved it'* *'It's a way [for] them to learn different things, but in a fun way'* *'He loved all the different instruments and making different sounds'* *'I could see that he was really enjoying himself. You know if he's happy, I'm happy'*	79 331-332 338-339 363-364
Specific benefits observed	*[Following assessment sessions when Baraq moved rapidly between instruments, then reduction of number of instruments in subsequent sessions] 'he was starting to spend more time on each [instrument]… getting him to concentrate more'*	351-353

	'He was starting to, erm, take in turns and things like that as well'	367
Beneficial for parent	*'I could see that he was really enjoying himself. You know if he's happy, I'm happy'*	363-364
Qualities of music therapist	*[Regarding the music therapist] 'she's lovely, she was really nice'*	385

Superordinate theme: Parent as expert

Theme	Transcript	Line from transcript
Parent knowledge improves music therapy process	*[It would have been better if the music therapist could have met with Baraq's parent beforehand] 'then she's got some extra ideas so she knows what kind of stuff …so he'll concentrate more… and do more in each session that way'*	401-402
Parent knows what children need	*[Response to question about school location of music therapy sessions] 'it's better in school cos… the children are familiar with the surroundings… they're safe and comfortable'*	472-476
Parental expertise validated when her suggestion improved music therapy session	*[Commenting on music therapist's adoption of parent's suggestion of making flash cards for the sessions]'it gave him a bit more structure and he liked doing it that way… that really worked for him'*	354-356

Superordinate theme: Religion and music

Theme	Transcript	Line from transcript
Baraq enjoys religious 'music'	*'At home he always listens to… naats and nasheeds… it's like spiritual music… religious music'*	39-42
Difference between spoken and recited words	*'There's a sura that he loves, from the Koran that, you know, it's different when it's being recited… it's really peaceful. He loves listening to that'*	179-182
Mother's voice lends different quality again	*'I pray, you know the nasheeds and that, I pray those as well, so he loves listening to that'*	189-190

Superordinate theme: Many languages

Theme	Transcript	Line from transcript
Mixture of languages in the household, and between family members	*[Which languages so you speak at home?] Urdu, Punjabi… it's sort of mixed, the way we speak… and English a lot as well*	254-256
	'With my parents it's more in our language, with my own sisters and brothers it will be more in English'	266-267
	'My husband only talks in Punjabi, both with me'	276-277

Baraq's mother really enjoyed attending the music therapy sessions with her son, especially because she could see him really enjoying himself and take pride in his achievements. Like Saif's father, her interview contains the 'Parent is expert' theme. She greatly appreciated having her opinions and knowledge asked for, and her devotion to her son was demonstrated in many of her answers. She valued someone taking time to get to know Baraq, and she also spoke of the need to recognise individual preferences within a given culture; this could be related to both experiences of people making assumptions about a person due to their cultural background, or perhaps making assumptions about a person based on the fact they have a disability.

The household has a mix of languages and identity. By her description of Urdu and Punjabi as 'our language' and the importance she places on her children spending time in Pakistan, Baraq's mother showed some of the nature of her family's identity as both British and Pakistani. She appreciated the music therapist listening to her and adapting the sessions accordingly. She also shared information about her personal practice of prayer, and how her son enjoys hearing her pray and finds this peaceful.

6.2.3 Interview three: Hameed's mother

Hameed has global developmental delay, resulting in limited physical movement and communicative abilities; he has no words but makes vocal sounds and can indicate preferences through facial expressions and reaching with his arms. Hameed is one of five siblings, three of whom have disabilities. Hameed's mother and father attended his music therapy sessions at school, participating in the session with great enthusiasm and obvious devotion.

Superordinate theme: Tensions between language and culture

Theme	Transcript	Line from Transcript
Children prefer to speak English	*[What language do the children speak?] 'more English yeah, they understand more*	67
Parent feels children should be speaking English	*'Usually we try to teach our kids English more cos you know over here it's more everything's in English'*	43-44
Family is Muslim, Pakistani, English, and Urdu/Punjabi speaking. In that order	*'Yeah we're Muslims and Pakistani, erm what else do you want to know?!'* *[Are there other influences?}* *'Yes, English and Urdu'*	28 43

Superordinate theme: Parent's supportive role

Theme	Transcript	Line from transcript
Busy household, the parent doesn't have time to herself	*'Three boys, two girls… three of them have disabilities'* *[Do you play a musical instrument or do you sing?] 'Not really don't have time'!*	32-33 117-118
Parent puts children first	*'I'm just a housewife'* *[Talking about what TV programs they watch]'It's just my kids, whatever they watch, just watch it with them'*	117 119-120
Both parents full-time carers	*'Both my husband and I don't work so we look after our kids; housewife… and house-husband!' [sound of laughing]*	33-34

Superordinate theme: Parent as expert

Theme	Transcript	Line from transcript
Parent understands Hameed's communication and methods of interaction	*[we] 'try to talk to him… and then like sign language'* *'If he's hungry he starts crying… and he blows kisses when he's really happy he starts clapping…If he's really tired and stuff, he starts crying'* *'He likes throwing balls… he's always throwing stuff on the floor and then the brothers and sisters pick it up and give it to him and he likes doing that'*	182 194-195 201-203
Parent knows his likes and dislikes	*'he likes playing with balls and musical, like, rattle or, erm drums…he likes musical toys that light up'*	197-198
Parent knows his preferences	*[What does he watch and listen to at home?] 'He likes Something Special…Mr. Tumble… Tikkabilla, Balamory, and Teletubbies, yeah Tweenies… He likes all the songs when the songs are on all the dancing around doing stuff he gets really excited. He loves that'*	145-149

Superordinate theme: Parent noticed benefits of Music Therapy

Theme	Transcript	Line from transcript
Music therapy is enjoyable for parent and child	*'He really enjoyed it because he was very excited… exploring all the different objects that he had to play with'* *'[I] really enjoyed it, very happy as well'*	220-221 230
Hameed enjoyed opportunities to have choice	*'He really liked it because he had a choice, you know, and she showed him, like two objects to choose from and he was really happy that he could choose'*	214-216
Music therapy offers a positive way to interact; hard to find with Hameed	*'cos he can't do anything, can't make choices and stuff, and he's got no speech and stuff… it makes you very happy when you see your child'*	240-241
Hameed developed new vocal sounds	*'Whenever the therapist was trying to make, er sounds, he copied them, so he's got a few new words as well'* *'He's got, like, new sounds, you know like verbal sounds'*	227-228 224-225
Good memories from music therapy sessions	*'I enjoyed being there, seeing him excited and being happy. So…it's like new… something new that he did, and he really enjoyed it and when he was laughing and clapping and getting excited so, made me happy to see him like that'*	235-237
Parent's pride in child	*'I think he did really well'*	228

In common with many of the families, Hameed's mother felt her children should speak English at home to support their engagement in English-speaking British society. She identified herself primarily as Muslim and Pakistani; the abruptness of her response to this question felt open, frank and positive, not at all defensive or negative as it might appear on the page.

She was devoted to her family and to Hameed, always putting his needs first and showing her in depth knowledge of his needs and how he engages with the world; she appreciated the music therapist's efforts to attend to Hameed, get to know him and have fun with him, and she felt pride and happiness in seeing another person understand something of him in the way she did, and the developments he made in music therapy sessions. The research assistant noted in her diary that she felt

Hameed's mother was delighted to see her son happy and having fun; nothing else really mattered to her.

6.2.4 Interview four: Maruf's mother

Maruf has global developmental delay resulting in very restricted movement, and limited communicative abilities. He communicates through facial expressions, and occasional vocal sounds. He is able to reach out to an object of preference from two options and hold a musical instrument.

Maruf was accompanied to some of the music therapy sessions by his mother and another family member, sometimes his father. They felt it would be beneficial for him if they were not always present, to see if he responded differently in their absence; they felt they might divert his attention away from the musical activities. Maruf's father and mother spoke little and no English respectively, so it was difficult for me to communicate with them during music therapy sessions. They were able, however, to understand the music therapy sessions, which were almost entirely non-verbal.

Superordinate theme: Culture - tensions

Theme	Transcript	Line no.
They feel an expectation to speak English at home with their children	*[What languages do you speak in the home?]* *'Punjabi'.* *[And your husband as well?]* *'When he interacts with her it's always in Punjabi, but in general it's always English, with his children and stuff like that'* *'The husband not being able to speak English fluently'*	161-164 336
They feel an expectation to listen to give particular answers	*Translator speaking: 'I was just trying to say to her… trying to find out like, what kind of music we like'*	126

Superordinate theme: Misunderstanding

Theme	Transcript	Line no.
Misunderstanding around interview	*['Are you translating for…?']* *'Yeah'.* *'[Caroline didn't explain to me that's what was happening']* *'She totally forgot about the appointment [this interview] to be honest'*	27-31 333
Misunderstanding of purpose of video material	*[On being asked why the family had refused permission for music therapy sessions to be videoed] 'She was er… well her response was… 'What was I going to do with the videos'. I was just explaining to her the videos were not for you they were for the researchers'.*	347-349
Use of informal interpreter; not interpreting all questions, using own judgment of her understanding, and adding own opinion	*'I'll just clarify if I think she doesn't understand'* *'Music in itself's like quite therapeutic, some music calms you down or whatever' (appears to be interpreter's own opinion, does not follow on from conversation with mother)* *'She thinks that music therapy means interacting with people which, in a sense, it kind of does but' (appears to be giving own opinion and contradicting mother)*	37 129 211-212

Superordinate theme: Mix of South Asian and UK musical cultures

Theme	Transcript	Line no.
All family members have their own relationship with music	*'[Maruf's mother] likes the Koranic recitations and stuff like that… she's not into Bollywood and stuff like that'* *'She don't understand most of the pop music'* *'[Her husband] 30% obviously similar to her like, like the Koranic recitations and stuff like that, bit of Bollywood here and there, but mainly it's like erm, and her children to be honest, most of them listen to radio and Westernised music'*	62-63 69 79-81
Children's changing tastes in music	*[the children] 'They're like one type of music one day then they change their mind another… but I could tell you… her eldest daughter's a big fan of Rihanna… And her younger son, I think he likes a bit of R&B'* *'[Maruf] prefers music with lyrics'*	150-156 195

Superordinate theme: Challenges of engaging with Maruf

Theme	Transcript	Line no.
He is non-verbal	*'Obviously if he could speak he'd tell me'*	241
He is lonely and isolated	*'Cos you know he is lonely… and sitting alone so, somebody somebody actually taking the time out of, who's not family'*	248-249
Hard to get to know him	*'in general, to be honest, he likes sounds… he likes any kind of noise, so whenever I get my phone out he can sense there's some music and start moving about. It's just general noise to be honest'*	188-191
He is getting older and bigger	*'When I'm holding him… when he listens to music he gets all excited and he's he's a big lad now and hard to control'*	301-302

Superordinate theme: Benefits of music therapy noticed

Theme	Transcript	Line no.
Child-led approach	*'You know not always dictated the kind of music, she was waiting for [Maruf] to make a sign and she'd follow that'*	278-279
One to one time	*'He really enjoys… someone spending a bit of time, basically quality time with him'* *'In general when he's in class it's… not always focused on him. I like the way your colleague spent time with him'*	224-225 276-277
Therapist's effort to attune to Maruf	*'She could tell that he was sad, and she made a noise that, what Maruf made, and she could tell that he'd responded in the way that he could feel that she knew how he was feeling basically, which you can tell with Maruf sometimes… if he's feeling sad you can give him a hug or something he can, he notices that you know he's sad. Obviously if he could speak he'd tell me though'*	236-241
Music; motivating for Maruf	*'He really enjoys… music'*	224-225
Form of interaction	*'It helps interact…it's a way of communication'*	209-210
Parent enjoyed seeing child happy	*'Basically she was happy that Maruf was enjoying it'*	257

As Muruf's mother does not speak English, I made arrangements for a staff member to act as interpreter (the school's usual practice with this family). As it happened, however, the family had arranged for Maruf's maternal uncle to interpret. This 'informal' interpreter made comments at times that appeared to be his own opinion based on his existing knowledge of the family and his brief contact with the music

therapist. The research assistant found herself prompting him to ask the mother for her own opinion. In her diary she wrote that she found it frustrating that she did not always seem to be getting Maruf's mother's answers, and that she had accepted the brothers answers too often. She did, however, feel that the brother's knowledge of the family was an advantage as she could hear his perspective.

This situation was in many ways far from ideal, as the unreliability of the interpreter meant it was not possible to be sure the parent's views were being represented. It did, however, provide useful insight for the research into how parents' voices may be restricted by a language barrier, even when they have made their preferred arrangements for language interpretation.

The language barrier caused further misunderstandings; despite an initial meeting at school before the music therapy sessions took place to explain the purpose of the research and gain consent, and at which an interpreter was provided, Maruf's mother thought the researcher's wish to video the music therapy sessions was to create a memento for her. This was only revealed at the interview following the music therapy sessions. Despite the language barrier, however, through attending Maruf's music therapy sessions his mother was able to see and understand some key aspects of the music therapy approach. She noticed how I would try and follow Maruf's lead, and how I tried to attune to his mood/affect in sessions.

Maruf's siblings speak English at home as well as Punjabi; in the interview there seemed to be an awareness of wider expectations of what should be done, from what languages should be spoken, to what music should be listened to. Maruf's mother appreciated the music therapist's efforts to listen to Maruf, follow his lead and get to know him. She also conveyed the challenges of having a child with Maruf's level of disability.

6.2.5 Interview five: Tahir's mother

Tahir has autism spectrum disorder and learning disabilities. He has no verbal language, but make vocal sounds and uses a few signs, e.g. hungry. He walks a little unsteadily but can move around a room by himself and pick up or point to what he wants. He knows what he wants and can be quite determined about whether or not he wants to do something or have something, but he is calm and gentle too, and engages with the world at a steady, relaxed pace. In the late morning assessment sessions Tahir was difficult to engage with and frequently made the sign for 'hungry'. Tahir's mother suggested I move the session to the earlier part of the morning to improve his conversation, and also that she would still come into school and wait outside/discreetly watch through the window but not come into sessions as her presence was also disrupting his concentration.

Superordinate theme: music and religion/spirituality

Theme	Transcript	Line no.
Music is not permitted in Islam, but the family listens to music	*'It's a tough one cos I mean really, culturally I mean, religiously we're not supposed to be listening to music or even entertaining the er idea of a, I mean come on rules are made to be broken [laughter from both] so we do listen to music'*	26-29
	'I'm a Muslim. We're not really supposed to, this isn't something that, listening to music we're not supposed to, the Qu'ran sees it as the work of the devil [laughs] so to speak so I mean it's music, I mean if it sounds nice to your ears you hear it, it's just how it is'	33-36
Permitted and forbidden types of music	*'Music, I think music where instruments are used is not allowed but I mean we're saying music is, nowadays there are religious erm, kinds of poems, they've added music to them so it's kind of varied'*	82-84
	'At the end of the day you're listening to something religious that's associated with your religion'	87-88
Parent justifies liking music	*'Anything that's good for the ears is good for people's soul, innit?!'*	92-93

Superordinate theme: Conflicting cultures/music and culture

Theme	Transcript	Line no.
Doesn't describe	*I: So which is your religious belief*	30-33

herself initially as 'Muslim' when first asked	*P: Erm from the Qu'ran* *I: OK* *P: Muslim, I'm a muslim [said very quietly]*	
Their family does not play instruments	*'No, nobody plays musical instruments [laughing], no the only ones that plays is the children. You know, just toys that make music'*	97-98
Learning instruments is not part of Asian culture	*'I think most Asians that I know or as far as I'm aware or the ones that I know nobody's children or even themselves don't play any instruments but you might get some very you know they're trying to act out like they're not Asians and they might get their child into that kind of thing but other than that I mean if you look here left right and centre nobody's child would be playing any sort of instrument'*	116-121

Superordinate theme: Communication and language

Theme	Transcript	Line no.
Two languages spoken at home	*'Punjabi and English'*	123
Parent is trying to encourage use of 'own' minority cultural language at home	*'[We speak] fifty fifty [of each language] but I'm trying to cut down on speaking English at home because eventually children will always speak that language… they'd start losing their own language'*	126-129
Husband has little English	*'My husband cos he's not very good in English'*	132

Superordinate theme: Parent as expert

Theme	Transcript	Line no.
Parent is able to communicate with son despite barriers	*'I talk to him, I kind of know what his needs are, when he wants what'*	146
Parent know son's abilities	*'He's his own person he will do what he wants when he wants, and you can't force him to do anything he doesn't want to do'* *'If he's interested in something he will do it but then he hasn't got that bigger concentration span'*	154-155 155-156
Parent steered music therapist based on her knowledge of her son	*'At the beginning I was sitting in the session with him and he wasn't paying [Caroline] any attention at all so I thought I'll just wait outside… and I think he did go better than when I was with him so'*	213-216

Superordinate theme: Benefits of MT

Theme	Transcript	Line no.
Parent has learned a new idea for interaction from music therapy sessions although is slightly	*'I: have you adopted any [ideas or techniques] at home when you're interacting with your son* *P: …sometimes she waited for [Tahir] to start something and she'd copy him or if she's doing, try and see if he follows her so that's the*	228-232

dismissive	*only thing we did'*	
Parent would have more music therapy for Tahir, despite noticing only modest improvements	*'I mean anything is better than nothing, even if he's erm a little focused on something it's better than having nothing at all'*	239-240
Son has made small difference in behaviour since having music therapy	*'Before when he had any toys or anything in his hand he'd just throw it on the floor, and now he ends up banging it on the table [raucous laughter from both]*	161-163
Music therapist listened to parent	*'She tried to accommodate us as much as she could'* *'The session that Caroline put us in as late mornings… those are really bad cos at that time he was like hungry and more focused on his tummy… but then when I suggested that she does the early session in the morning so as soon as he comes in to school. So he got a bit out of it and I think I got a bit out of that as well'*	199 246-252

Tahir's mother had a strong character and sharp wit; the recording from her interview is full of laughter as she entertains the research assistant with stories and quick retorts. Without being asked, she immediately talk about music being forbidden in Islam, but how she and her family listen to music in different ways, music is good for the soul, and that religious poems set to instruments exist and are most likely not forbidden as they are religious. She also said that none of the 'Asians' she knew in her local area played instruments or had their children have instrumental lessons; she felt this was going against culture and they were trying to be something they were not. Tahir's mother spoke very good English, her husband spoke very little English, and at home she was keen for the family to talk more in Punjabi so the children could maintain their language as they speak English elsewhere.

Tahir's mother was ambivalent about music therapy on the whole. She felt that she had seen no great changes, but on the other hand thought it was better than nothing and would like more for Tahir if it was offered. She personally seemed to get something out of the research project; she was listened to and had her opinions taken seriously, on her subject of expertise, her son.

The research assistant commented on how easy she found it to get a positive and friendly connection with Tahir's mum. She felt she was really aware of cultural differences, offering comments to clarify information, and had thought about and engaged with the topic of cultural difference.

6.2.6 Interview six: Saeed's father

Saeed has profound and multiple learning difficulties. He has very poor hearing for which he has hearing aids, which he wears some of the time. Aims for music therapy sessions involved giving him a range of experiences of sounds, timbres and textures; encourage vocalisation and give him opportunities for choice and control. He became more animated at particular sounds, and at times withdrew his hands from instruments placed in them. At other times it was very hard to identify any response or reaction. His mother and father attended some of his music therapy sessions.

Superordinate theme: Integration – culture - tensions

Theme	**Transcript**	**Line from Transcript**
Similarities and differences between UK and Iranian culture	*'North of Iran more or less has got pretty similar to Western culture'* *'people expression of the friendship is a bit different but there still is understandable'* *'it seems to be here that interaction is maybe a little less friendly than in my country'*	62-63 80 75-76
Barriers to integration; **age** [parent is middle aged, and seems to imply integration gets harder as we get older] **misconceptions**	*'I try to integrate as much as I can but obviously in terms of my age it can be a bit difficult'* *'Let's forget about the British media… What is reality? I'm telling you the reality'*	53-54 65-67
Parent consciously integrates himself	*'Anyway, therefore I find it more or less not, um more or less okay to er, the best word tailor myself or adjust myself within this culture'*	71-73
Parent feels integrated	*'I think… you can say integrated'* *'There has been no significant cultural difference'*	51 69-70

Superordinate theme: Staying connected

Theme	Transcript	Line from transcript
Use of the voice at home	*'sounds you can hear in my home is our conversations rather than anything else… we try to you know talk more, even [if] we know [S] might not understand or hear very well, we try to contact him not just with touch , we try to talk to him whether we're going to do or whether we ask him. We try to keep him in our family'*	115-121
	'human voice he likes probably a little but apart from that, I think drum, one instrument that he likes definitely is drum'	182 – 183
Dialogue is not possible due to disability	*'Interaction is … not dialogue… because [S] has got a lot of, you know, limitation, limitation of having an input from outside therefore the amount of information he can get from his environment is very restricted'*	190 - 193
Connection with music therapist	*'I think she has got good listening, she was listening to whatever we say to try to keep engaged with family as well which was quite positive'*	270 - 271

Superordinate theme: What is music therapy? MT as an approach

Theme	Transcript	Line from transcript
It is not therapy	*'You know the word therapy is not the best word we can use. I'm sorry.[…] Because in therapy we are aiming to improve something, getting for example something better… I don't know how much [S] has got any sort of, you know, treatment or because of his situation'*	252 – 257
	'I was not looking for example to having any sort of difference or improvement'	213 – 214
	'Entertainment rather than having anything that, for example, learning thing'	217
It is useful/enjoyable	*[What did you know about music therapy beforehand?] '[It] was my feeling, yeah, that he would enjoy that. And he would have some good time, that was my impression'*	212 – 213
	[S] tried to keep focus on what's going on around which is quite good for [S] and er, he seems very keen, he seems to engage himself with [music therapy]'	223 – 224
	[What do you think he got out of the sessions?]I think… the best word is enjoyment rather than anything else'	232
	[The music therapist] was really fantastic,	332 - 335

	she has done a fantastic job I think, that was my impression and I believe [S] definitely if it's not going to continue [S] definitely miss, miss one of the maybe probably he enjoyed most, one of the enjoyment in his life he really like'	
Family have learned skills	*'because he has got a drum at home, we try to interest him in play drum or anything else… but the thing was different is probably the way she used to follow…In Caroline's session which we didn't before, try to er give [S] some sort of control of the session rather than all control from the parents'*	299 - 308

Saeed's father was interviewed. He felt well integrated into British society but was aware of differences and similarities between British and Iranian culture, and had consciously made efforts to integrate himself, although he felt his age was a barrier (he thought cultural adaptation became more difficult with age). He also raised another barrier to integration: the public making assumptions about a foreign culture due to the media promoting a particular perception of a country.

He felt that music therapy should not be described as therapy (he himself was a highly qualified health professional). Although he felt that music therapy sessions had offered his son something valuable and unique, their main attribute was that they were enjoyable rather than therapeutic; that improvement could not be expected.

6.2.7 Interview seven: Bartosz's mother

Bartosz was a boy in his early teens with autism spectrum disorder and mild to moderate learning disability. He could speak in short (two or three word) sentences. He was fairly difficult to engage in activities with. He had fixed, limited interests, from which it was hard to entice him away, or develop into a wider activity. Aims for Bartosz's music therapy sessions included giving him a means of being expressive and creative through the use of music and musical instruments, to develop confidence and concentration, to form a relationship with the music therapist.

Superordinate theme: Communication and language/misunderstanding

Theme	**Transcript**	**Line from Transcript**
Parent could understand some of the questions and sometimes replied herself, but every word was carefully translated, leading to frustration	*Parent: 'Here [in UK] it's me and my husband, [Bartosz] and my sister. And my parents at home and some siblings'* *Interviewer: 'In Poland?'* *Parent: 'Yes' [Parent overlaps with interpreter who translates frustrated sounding utterance as 'Of course']*	38-42
Despite having little English, she and Caroline were able to communicate	*'I partly could understand Caroline, what she was talking about'*	214-215
The complexities of culture and/or music therapy were not easy to discuss via an interpreter	*Parent: 'Er, [Bartosz] has always liked dancing but her can show us certain things when the music is on, he can, er, do other things when the music is on, for example when the music is on he dances a bit but afterwards, after some time he moves to er doing jigsaw while the music is still on' [long silence]* *Interpreter: 'I'm just interpreting'* *Interviewer: 'OK I think I understand'* *Parent: 'It's difficult to explain'*	168-174

Superordinate theme: Noted benefits of MT

Theme	Transcript	Line from transcript
Parent has noticed changes in her son she attributes to music therapy	*'I know, but it's my opinion, I've seen changes in [my son]'* *'Before [my son] liked listening to one particular song all the time but now he's learned different patterns, musical patterns, he's listened to different songs and sometimes he tries to copy the lyrics from songs'* *'He can watch videos with the children who dance, who jump er and he can copy their movements… before he didn't do that'*	195-196 198-202 204-206
Understanding of music therapy from involvement in project	*'It makes [Bartosz's] focusing and concentrating better on what he does, he seems much calmer he can concentrate better on what he's doing'*	143-145
Parent uses ideas from music therapy sessions at home, using music to support other tasks	*'I've learned through the sessions er about the appropriate approach, how to work with him, how to make him do things'*	153-155

	'[Bartosz] has always liked dancing but he can show us certain things when the music is on he dances a bit but afterwards, after some time he moves to er doing jigsaw while the music is still on'	168-172

Superordinate theme: Parent as expert

Theme	Transcript	Line from transcript
Parent knows what Bartosz enjoys	*'[Bartosz] quite likes when somebody sings to him, when somebody reads books to him, he likes books'* *'He often helps me when I'm in the kitchen, er he helps me prepare food, whatever he can do, he does. He has great fun when he's with me in the kitchen'*	131-132 135-137
Parent knows how Bartosz learns	*'You can't really teach him anything if it's not through play'*	132-133
Parent has strong opinions on her son	*I know, but it's my opinion, I've seen changes in [my son]'*	195-196

Superordinate theme: Cultural differences

Theme	Transcript	Line from transcript
Parent feels there's no/little cultural difference between UK and Poland	*'Interviewer: Could you describe your cultural and ethnic influences in your family and your family's background? Parent: There's no influence really'* *'the traditions in Poland and similar to this country's. We celebrate Easter and Christmas so the lifestyle is pretty similar'* *[On being asked how music is used in Polish tradition] 'It's used quite normally'*	26-28 46-48 73
Parent has Polish and English friends	*'Our Polish friends speak Polish and English but we've also got friends who are English'* *'I spend most of my time with my family especially my sister, with some friends, but I also meet people of different nationalities. I'm trying to learn English at school, that's where I meet them'.*	55-56 66-69
Initially hard settling in UK	*Interviewer: 'Did you find it easy coming to England and living here?' Parent: 'It was hard at the beginning but we got used to with time'*	49-52

Superordinate theme: Checking on parent/role of researcher

Theme	Transcript	Line from transcript
Mistranslation or parent feels researcher is checking up on her?	*[When asked about the people she socializes with] 'They're okay, my friends'* *[When asked how she interacts with Bartosz] 'It's fine'*	60 128

Bartosz's mother spoke very little English so a professional interpreter was engaged. The research assistant addressed all her questions to Bartosz's mother, and the interpreter translated every word spoken by each of them. The research assistant found she had to work hard to make sure she communicated positively with Bartosz's mother non-verbally, for example maintaining eye contact and interest when the interpreter was speaking. She wrote in her diary that she found the interview cold and stilted compared to the other interviews including the one with interpreted by a family member, although she did feel it was easier in some ways as she could trust the interpreter was translating every word. She also felt that Bartosz's mother had more to say on the subject but the research assistant was not able to explore further due to the language barrier.

There were a few moments of frustration on the part of Bartosz's mother during the interview; she did understand some of the questions, and some of the answers, and seemed impatient at the interpreter's careful translation of every word. This was also the great benefit of using a professional, however; the research assistant could be confident every word was being translated. At other times the interpreter made a translation of an answer, which did not seem to make sense, and the research assistant prompted her to ask the parent again. It seemed that the words to describe non-verbal interactions are not always easy to find, making them hard to then interpret across a language barrier.

Bartosz's mother felt she had noticed positive changes in her son that she attributed to music therapy sessions, and gave her opinion on this as the person who knows him best. When answering the questions on cultural difference she was very clear that she considered there was no difference between Poland and the UK, and had experienced no barriers. She was so definite in her answers I wondered if she was being defensive or had mixed feelings on this topic. Perhaps it was part of her determined character to have a positive outlook, or part of the researcher's determination to find cultural differences in the interviews!

6.2.8 Interview eight: Aryan's mother

Aryan has autism spectrum disorder and learning disabilities. He is able to walk a little but mainly uses all fours or shuffles on his bottom to move around (when not in a wheelchair). He explores the world using touch; he grabs objects with some force, exhibiting behaviour which sometimes challenges others. He mouths objects and transfers his saliva to them using his hands. He expresses his emotions through vocal sounds and facial expressions; he has a beautiful, wide smile which he would show me in music therapy sessions when I demonstrated I understood a need of his, e.g. playing a particular instrument or answering a request of some kind.

To give Aryan a level of choice and freedom I arranged the music therapy room so it was free of all items except for musical instruments scattered around so he could move freely, choosing instruments to play, and which I would then use to interact with him.

Superordinate theme: Awareness of outsider status

Theme	Transcript	Line from Transcript
Parents have consciously adapted to UK life	*'We have tried to adapt fully to… the culture here because we worked with a number of people here'* *[We have] a good understanding of the culture here…the regional differences as well as the general culture'*	37 44

	[We speak] 'Hindi and English at home… With my children I try and speak English, er with my husband it can be anything really!'	155-156
Mix of cultures	*'My colleagues from work are mainly British and my friends could be Indians, and there are some Indians who have married British as well'* *'But sometimes in the privacy of your own home you are ready to go back to your roots and practices'* *'If you go out to eat with your colleagues at work it will feel a completely different environment… and you might talk about different things but if you get invited for dinner at a friend's place who's from India the conversation around the table, the food etc. can be different'*	86-87 49-50 56-61
Values at core of cultural identity	*'my upbringing has got a stronger influence [on my life than British culture] but it's not the practices and traditions as such but the values'* *'the values are very strong, they're inbuilt, they're our most erm, yeah they're the core and that influences my work style, my parenting style and other things'*	67-68 74-76
Other people can make assumptions/parent educates people about her culture	*'Do you know about India'… 'India is very diverse culturally itself… it has got a number of states and languages and traditional, erm I mean beliefs and practices'* *'Well I personally like Bollywood songs… Have you seen them? They're very diverse, they can be quite catchy'*	27-32 120-122

Superordinate theme: Busy-ness/free time

Theme	**Transcript**	**Line from transcript**
Parent has a very busy life	*'I don't really get a lot of time' [when asked about social activities]* *'It's difficult for me to imagine that I would have that kind of luxury' [to attend music therapy sessions/be without work commitments]*	134 319-320
Home and school are both busy/demanding environments	*'Unfortunately at home also there is, although it's a low demand environment compared to school, if parents are working and rushed things have to happen in a… structured way, yeah, and there is an agenda at school as well… so I think, um, unfortunately for these*	224-230

	children to express themselves and build up their self-esteem is sometimes lost somewhere'	
Parent recognized this quality in MT	*'Well I was quite impressed to be honest because erm I was telling Caroline that unfortunately what tends to happen is that everybody has an agenda with these children, you're supposed to do this, you know?... 'This is your waiting time, this is your feeding time, this is changing time, you have to go out, this is a swimming session'. So what I saw is it is important to keep everything aside and, you know, just, just forget about all the demands and, and relax and have some positive interaction together'*	215-222
Parent has taken away idea of creating time without agenda with son	*'[Is there anything you've learned from the music therapy sessions?] 'It would be great to kind of, you know have some time where you put aside all your tasks and your own demands and you can relax first in order to allow him to relax'*	291-293

Superordinate theme: Characteristics of music therapy as approach

Theme	**Transcript**	**Line from transcipt**
Both structured and flexible	*[Did you have prior knowledge of music therapy?] 'I didn't know that it could be delivered in such a structured way to er learning disabled people'* *'It's a great positive approach but it requires a lot of er tuning in and letting go and a flexible style'* *'Although it is structured, er, it has got to still be flexible according to the child'* *'my son taking the lead in terms of what he wanted to play and even in the small interactions where there was some turn-taking and there was fine-tuning'*	210 244-245 247 250-252
Promotes listening, understanding and self-esteem	*''Most of all it helped him feel good because somebody was listening to him, understanding what he was trying to communicate and, and, and giving it to him… so that made him feel good and it must have improved his self-esteem… and he didn't have to resort to any unpleasant behaviours to get attention'* *'to try and ah give a safe space to allow expression and to allow some healing if there is a problem'*	235-241 204
Different to other approaches parent has experience of	*'I think it was useful for him [child], yes, because he got a different, calm, relaxing experience where somebody else was*	260-262

	trying to, you know, work according to both listening to him'	
Music therapist's character comes in to play	*'I mean I'm just thinking, I mean what Caroline did was great but I'm thinking in terms of how you would respond if there was a lot of energy in the instruments or in the music, would that enthuse him more or er, giving him this quiet, safe space was perhaps more important? I'm just curious to know how he would have responded'*	272-276
Cultural difference less relevant than being able to tune in to another person	*'I don't think music depends upon language or any other… It probably er, it depends on how you tune in with the person if there is non-verbal communication'*	283-286

Superordinate theme: Research promotes music therapy

Theme	**Transcript**	**Line from transcript**
Music therapy is not well known/understood	*'It's more like a method of interaction really…but I mean, ah only after people know, they can think about and plan something'*	364-367
This project provides an opportunity for children, parents and teachers	*'I think the study gives er, parents an exposure to music therapy, those who are… not heard of it or known it before and it gives er, these children a good opportunity… or having a safe space and some expression and probably erm, gives some exposure to the teachers as well… to think about these kind of things in school'*	352-360
Longer term intervention would be more valuable	*[Was the music therapist successful at achieving the therapy aims?] 'I think so, but I think it does need a longer investment in terms of time and effort if it were to generalize to other situations'*	257-258

Aryan's mother was not able to attend any music therapy sessions due to her work commitments, so her knowledge is based on the end of therapy report and time spent with me viewing videos of sessions.

She described she and her husband's conscious actions to adapt to UK culture following their move here from India almost 20 years ago, mainly to help with their work. They have friends from British and Indian backgrounds, but she spoke too of

her need to return to her roots at times, and that the values she got from her upbringing were the strongest factor, more so than the practices and traditions. Some of her answers suggested she often finds herself needing to counter cultural assumptions; the examples she gave were of the diversity within India itself and within Bollywood music.

Aryan's mother noticed various characteristics of music therapy; its child-led nature meaning agendas could be put to one side and the therapist can focus on really listening to and offering quality time to the child, in contrast with the demands of other school and home-based situations. She noted the flexibility and structure within music therapy which helped her son to have an enjoyable experience of interaction, which she felt in turn built up his confidence and self esteem.

Aryan's mother raised the issue of the character of the music therapist; she wondered if a more lively, energetic style might have had a different effect with Aryan. I have a gentle, calm style; this is part of my character so is usually present when I am interacting authentically with someone in music therapy. Finally, she felt that involvement in this research project gave her and the school the chance to learn about music therapy, an approach she had little knowledge of before.
This was the only interview to take place in the family home. As Aryan's mother worked full time this was the only way she could accommodate the interview. The research assistant felt the experience was easier for the parent than for her, that it felt different to the other interviews, which took place on 'neutral territory'. The contrast between the ease of the parent in her own home and the other parents in the school environment could suggest that the school environment is not necessarily neutral ground for these kinds of interviews.

6.3 Discussion of superordinate themes

This table shows the incidence of superordinate themes across the interviews. Some themes were common to many parents, whilst others only resonated with one or two. As discussed below, some themes occurred frequently because they were closely linked to the subject matter in the questions so would inevitably recur throughout the interviews. For example, the superordinate theme 'benefits of music therapy' was addressed by all parents because they were directly asked to comment on this topic. Following this table, each of the superordinate themes is discussed.

	Superordinate theme	Saif	Baraq	Hameed	Maruf	Tahir	Saeed	Bartosz	Aryan	Total
1	Communication and language	x	x			x	x	x		5
2	Misunderstanding				x			x		2
3	Parent as expert	x	x	x	x	x		x		6
4	Cultural tensions		x	x	x		x	x	x	6
5	Music and culture	x			x	x				3
6	Religion and music		x			x				2
7	Benefits of MT	x	x	x	x	x	x	x	x	8
8	Emotion and personality in MT	x								1
9	MT approach						x		x	2
10	Research promotes MT								x	1

Table 4 Table of superordinate themes from all interviews

6.3.1. Communication and language

This was inevitably a theme across many interviews as it related to the inclusion criterion for the children; that English was not the first language spoken at home.

Interestingly, parents had conflicting ideas about using English at home. Some parents were keen to maintain the language(s) of their cultural background for their children. Baraq's mother said 'All the kids talk a lot in English, but I'm trying to get them to talk more in our language so they don't lose that' (transcript parent of Baraq line 259-260) and 'they speak 'Urdu, Punjabi…it's sort of mixed, the way we speak… and English a lot as well' (transcript parent of Baraq line 254-256). I was struck by her use of the phrase 'our language'; revealing the importance of her ethnic language and heritage. Bartosz's mother spoke about her parents 'at home' , and when asked by the research assistant to clarify where she meant; 'in Poland?', she replied 'of course' (transcript parent of Bartosz line 38-42). To her home is Poland; not where she and her immediate family are settled, but where she grew up and where her parents and extended family are.

Other parents said they used English at home, expressing an apparent obligation to use the language of the country and education system in which they lived. My impression from the transcripts and also my research assistant's impression, was that some of those families exaggerated how often they used English at home, perhaps partly because it was what they felt was the cultural expectation. There were contradictions in the parents' descriptions of language use at home. Tahir's mother said they speak 'Punjabi and English… fifty fifty' (transcript parent of Tahir line 123- 126) but also that her husband is 'not very good in English' (transcript parent of Tahir line 132). As her husband speaks little English it is likely they speak more Punjabi at home, as well as the fact that this language was listed first, so perhaps is their main language. Similarly, Maruf's mother had little English and required an interpreter for the interview, with her 'husband not being able to speak English fluently' (transcript parent of Maruf line 336) but she also said that when her husband 'interacts with her it's always in Punjabi, but in general it's always in English, with his children and stuff like that' (transcript parent of Maruf line 161-164).

This indicates that there was possibly not much English spoken at home by the parents.

All the families had a rich web of different languages being used between different family members and generations; these languages also included forms of sign language. Speech was often used as a means of connection between parent and child, despite the likelihood the child was not able to understand the meaning of words, but the parent felt the sounds and rhythms of speech connected them to their child. This included the sound of their own religious chanting or prayer. For example, Baraq's mother said, 'I pray, you know the nasheeds and that, I pray those as well, so he loves listening to that' (Transcript parent of Baraq line 189-190). This issue will be addressed at greater length in point number six below as 'religion and music' emerged as one of the superordinate themes.

6.3.2. Misunderstanding

This theme emerged from the interviews for which interpreters were required, i.e. for those families for whom there was a significant language barrier. There was one such family in each school. For the research project I had chosen to follow the school's own procedure in each example (a professional interpreter engaged from an agency in one school, and a staff member in the other), although in one school the family chose to bring their own family member rather than use the member of staff who usually interpreted for them. I had arranged for the school to release this staff member from her duties for the interview and she had let the family know she would be available. Despite this the family brought their own interpreter. In the event, the presence of both the formal and informal interpreters brought their own issues and while they no doubt helped overcome the language barrier, they did not by any means circumvent it.

The informal interpreter was unreliable, offering his own opinions and knowledge, and clearly not always asking the interview subject, his sister, for her views. For example, there is a point in the interview at which the brother has been interpreting his sister's words, then the interviewer makes a comment that some people think you have to be musical to have music therapy, and the interpreter immediately interjects with 'Music in itself's like quite therapeutic…', a new idea in the conversation which does not come from Maruf's mother (transcript parent of Maruf line 127-129). When the interviewer asked about the family's background, the interpreter said, 'I'm her brother so is it alright if I just tell you about her background?' (transcript parent of Maruf line 54). At another point he described his role; 'I'll just clarify if I think she doesn't understand' (transcript parent of Maruf line 37). He was using his own judgment of his sister's linguistic ability to decide when to interpret, rather than translating every word. A trained or professional interpreter would not offer their own opinion or knowledge, rather interpret as faithfully as possible only what the interviewee was saying. Kriz and Skivenes identified a number of pitfalls when using interpreters from ethnic minorities in a social work context including interpreters without adequate training who did not translate every word (2010 p. 1361). He was, however, knowledgeable about the family and Maruf, and did help clear up misunderstandings, such as the reason the family did not want the music therapy sessions to be video recorded; the interpreter questioned his sister on this point and was able to find out the reason she had declined videos of the sessions; 'her response was 'what am I going to do with the videos' I was just explaining to her the videos were not for you they were for the researchers' (transcript parent of Maruf line 347-349). He also shared details of family life that illuminated Maruf's experience, and might not have been revealed had Maruf's uncle been involved in interpreting. At a particular moment, almost as an aside to illustrate a point that may well have come from Maruf's mother, and immediately after a comment from the interviewer without time to talk to Maruf's mother, the interpreter who obviously knows Maruf well and

spends time with him at home said ‘Yeah cos you know he is lonely’ (transcript parent of Maruf line 248) and again later says ‘he’s a big lad now and hard to control’ (transcript parent of Maruf line 302), comments that reveal something of his and Maruf’s experience.

The professional interpreter was more reliable in the sense that she dutifully interpreted every word between the parent and the research assistant. Sometimes, however, it seemed that the absence of non-verbal cues between the parent and research assistant created a greater distance, or that had there not been a language barrier the research assistant and parent may have discussed certain points back and forth until they had found a shared understanding of a particular point. She was certainly proficient in language but there was an absence of the true dialogue between the parent and the research assistant that a shared language allows. A contrast with this could be found in the interview with Hameed’s mother. She relates the cheerful chaos of their household in a humorous exchange with the interviewer. When asked about what sounds might be heard in her house, she says ‘Sounds of screaming! [laughter] Crying mostly, banging, throwing stuff, yeah, breaking things [laughter], And music, loud music’ (transcript parent of Hameed line 130-131). The laughter shared between the parent and interviewer is enthusiastic and reveals a developing rapport between the two which no doubt facilitates the trusting relationship ideally required for the interview.

The use of interpreters placed the focus on the words shared between the interview dyad, rather than the co-creation of meaning that takes place when people communicate with verbal and non-verbal methods together. Words convey meanings, but body language reveals the emotions and motivations of the speaker, relevant if the interviewer is trying to draw sensitive material from the interviewee. In their research into the use of interpreters in social work, Kriz and Skivenes observed

‘information deficits, more curtailed relationship-building processes, feelings of mistrust and practical obstacles for minority ethnic caregivers’ (2010, p.1358).

Bartosz’s family knew their interpreter a little, because she had happened to have been engaged to interpret for them on a number of occasions in the past, and this highlighted another potential issue. While seemingly not a problem in this instance, the use of interpreters from a small community where everyone is known to each other might discourage people from either using them or speaking frankly in sensitive situations. This phenomenon has been observed in research; ‘families fear loss of confidentiality when talking to social workers via an interpreter, who may belong to their ethnic community’ (Kriz and Skivenes 2010 p.1360).

6.3.3. Parent as expert

This theme emerged across many of the interviews sometimes in slightly different forms. Saif’s father seemed keen to reinforce his expertise on his child in terms of knowing the child and his needs best, with an apparent experience that the parent’s voice was not heard or valued as often as it should be. Blair and Bourne’s research in a multi-ethnic school in London found parents expressed concerns about ‘racism, stereotyping, and lack of respect for parents and for students’ and ‘poor communication, lack of understanding and missed opportunities for effective partnership between parents and schools’ (1998 cited in Page, J. Whitting, G. and Mclean C. 2007 p.77). Other parents valued the music therapist’s willingness to incorporate the parent’s ideas into sessions, which implied their knowledge of their child was not sought as often as it might be. These parents made suggestions to help the music therapist, and expressed a sense of gratitude at being listened to and their expertise being respected. For example, Baraq’s mother suggested the use of flash cards denoting the musical instruments available in the room as Baraq enjoyed using these cards at other times; at home and in the doctor’s waiting room. The

music therapist made a set of cards and used them as the basis for musical activities in music therapy sessions, such as matching the cards to the instruments, or each person drawing a card to indicate which instrument they would play next. Baraq's mother commented on how this strategy was successful, 'it gave him a bit more structure and he liked doing it that way… that really worked for him' (transcript parent of Baraq line 354-356) and suggested the music therapist should take on more parental suggestions before music therapy sessions commenced, 'then she's got some extra ideas so she knows what kind of stuff… so he'll concentrate more… and do more in each session that way' (transcript parent of Baraq line 401-402). There are occasions, of course, where a music therapist may choose not to take on the suggestions of a parent; therapy work in which a difficult parent-child dynamic is being explored may not be helped by the parent and therapist meeting without the child, and it may be that the parent's suggestion would not fit with the model of therapy practiced by the music therapist; any proposed suggestions would need to be harmonious with the music therapist's own approach. Although the parent is the expert on their own child, the music therapist is the expert in their field, and where appropriate such collaborations with parents may be very helpful.

All the children in this research project experienced significant levels of disability which impacted on the way they interacted with the world, communicated with others, and on how they expressed their emotions and their character. The parents were the ones who best knew all the little details of the children's lives; what their unique sounds and expressions meant, and how their sons were changing from day to day. They also were the ones who most loved their children and devoted themselves to their care. Some of the parents seemed to express resignation at their experience of not always being listened to and perhaps, had been institutionally encouraged to play down the importance of their role. Hameed's mother, at one point, said 'I'm just a housewife' (transcript parent of Hameed line 117). Bartosz's mother said, 'No, I know

but it's my opinion' (transcript parent of Bartosz line 195-196) in response to a question about the benefits of music therapy, with a possible interpretation of her opinion being worth little in some eyes, but nevertheless she knew her opinion on the matter and would state it to anyone.

The ethical considerations of this research project meant that informed consent was gained from parents in all aspect of participation, including the recorded interview. Some parents clearly appreciated this experience and commented on it, 'She's [the music therapist] amazing, she's absolutely fantastic. She's very professional and down to earth and erm, she's she's engaged with us and the er, and [Saif]. She's asked our permission for everything from day one' (transcript parent of Saif line 216-219). This seeking out of the opinions and preferences of the parents was not only due to the ethical requirements of the research project; it took place throughout the music therapy sessions where parents were present. Baraq's mother felt further conversations around Baraq's musical preferences could have further enhanced the sessions, to find out, 'a little more about him, and his background, and pick [the parent's] brain a bit before…just so she could have some extra ideas' (transcript Parent of Baraq line 398-400).

Parents can (and should be enabled to) inform the professional, and working with parents in sessions is not uncommon in music therapy practice. In her work in a child development centre, Oldfield invariably works with primary carers in the room for a number of reasons; parents can provide practical support, such as guidance with physical positioning of the child and with medical devices; the parents value seeing their children both enjoying themselves in the session and gaining new abilities, and Oldfield uses the music therapy sessions as a way to strengthen the bond between the parent or caregiver and child (2006 p.113). Drake (2011) works with children and their adoptive parents to 'help the child to begin to trust the parent to respond to them

with love and offer them security' through finding 'the basic pulse to which their relationship can become attuned' (2011 p.24). Not only are parents the experts on their child, but the parent child relationship will endure long after music therapy sessions have ended. Supporting the parents in finding new, positive ways of relating to their child will most likely have far longer term benefits than the relationship with the music therapist alone, and engaging the parent in aspects of the music therapy approach by listening to them, showing interest in their suggestions and encouraging them will build their trust and make them feel supported and valued. Parents of children with disabilities are on a difficult, isolating road, and a listening, collaborative, positive music therapy approach can offer genuine support for parents and improve experiences for their children.

6.3.4. Cultural tensions

Some of the parents spoke of how they were trying to maintain aspects of their familial culture in how they brought up their children, either their language or through trips back 'home'. Several parents seemed to reply with what they felt they should be seen to be doing or saying, rather than speaking of their experience without any kind of filter. For example, the interpreter brother said to the research assistant, following conversation with his sister, said, 'I was just trying to say to her…trying to find out like, what kind of music we like' (transcript parent of Maruf line 126). I wondered what he meant by 'we'; he already knew what he liked, and could have used 'she' to refer to her taste only. Did 'we' refer to the whole family? Their cultural group? Use of a research assistant was an important part of the research design, with the intention that parents would feel more free to comment on the music therapist if I was not also conducting the interview. It meant, however, that I was not able to interrogate the meaning behind some of the parents' questions as I would have liked.

I noticed from listening to the recordings of the interviews that there were moments when it seemed the parents were very conscious of their minority status in the UK; when asked about her identity, Hameed's mother said she was Muslim and Pakistani; 'what else so you want to know?!' with almost a challenge, albeit a friendly one (transcript parent of Hameed line 28). Tahir's mother, when asked about her religion initially said she followed the Qu'ran, before saying very quietly that she was Muslim (transcript parent of Tahir line 30-33). I wondered if she wanted to acknowledge her religious identity in a different way to how I (or the research assistant) might expect it. Perhaps this connected to a previous reception of her religion by someone outside her community. Framing the description her religious as 'from the Qur'an' rather than 'Muslim', which might be more commonly expected, might be inviting the interviewer to put preconceptions of what it means to be Muslim to one side.

Some of the parents talked about how they made a conscious effort to integrate into British society. Saeed's father felt this process of integration got harder with age, and was hindered by unhelpful portrayals of his home country, Iran, in the British media. Aryan's mother felt she was well integrated, with friends from different cultures; '[We have] a good understanding of the culture here… the regional differences as well as the general culture' (transcript parent of Aryan line 44), but found sometimes she wanted to spend time with people who shared her background and values; 'sometimes in the privacy of your home you are ready to go back to your roots and practices' (transcript parent of Aryan line 49-50). Part of her approach to integration was to educate others about her own culture; a couple of times during the interview she took the opportunity to gently ask if the research assistant knew about her home country, drawing attention to the cultural diversity within India itself; 'It has got a number of states and languages and… belief and practices' (transcript parent of Aryan line 27-32) and variety of musical styles within Bollywood music, 'Well I

personally like Bollywood songs… Have you seen them? They're very diverse, they can be quite catchy' (transcript parent of Aryan line 120-122). Finally, Bartosz's mother was adamant there was no or very little difference between the culture where she grew up and British culture, describing the family's use of music with the word 'normal'; perhaps she wanted not to be seem as 'abnormal', or to be able to fit in inconspicuously. She was the only parent interviewed who could be described as belonging to an 'invisible minority' one of the many ethnic groups in the UK who do not identify as 'non-white', such as the Irish, Greeks, Turks, Cypriots and travellers, but who belong to a minority ethnic group (Aspinall 2002 p.809).

This superordinate theme revealed the tensions between maintaining the minority ethnic culture whilst engaging with aspects of majority culture; trying to anticipate what others in the majority culture expect, and sustaining familial or ethnic identity with others who share their values, practices and traditions.

6.3.5. Music and culture

Five out of the eight families identified themselves as of Pakistani, Muslin heritage. From some of the interviews, it emerged that playing instruments was not common, and that there could be tensions around music in Islamic culture. Tahir's mother said that learning to play musical instruments was un-Asian (herself being part of the Asian/British-Pakistani community) and if members of a family were doing this they were acting against their culture. She found such a strong link between a particular culture and not learning musical instruments and I found this to be a particularly interesting comment; given that other parents were commenting on the need to focus on the individual before considering their wider cultural context, while she was making a general statement about music in her own cultural group.

Other families in this research did speak about different family members playing musical instruments. Saeed's father, from Iran, used to play guitar and his sister played the piano (transcript parent of Saeed line 105-107). Aryan's brother (Aryan's parents are Indian) played the drums in a heavy metal band line (transcript parent of Aryan line 102-106). None of the families of Pakistani origin, however, mentioned that any immediate family member played an instrument. The only one was Hameed's mother, who said that some relatives abroad played, 'A few of my cousins just sing abroad you know like, two drums and flutes and singing' (transcript parent of Hameed line 109-110). This could indicate learning musical instruments is not common amongst members of the Pakistani diaspora in the UK.

Across the two generations, the subjects' generation listened to less music from their minority cultural background than their parents. The research subjects were restricted in their ability to make choices or influence their environment by their disabilities, but it might reasonably be assumed that they would be more likely to have similar musical tastes to their siblings and other children of their generation, than their parents' generation. This point is significant because the parents have been interviewed to give perspective on the home lives and experiences of the subjects, but in this example the siblings' choices might well be closer to the preferences of the subjects.

It seemed to be the case across many of the families that the parents' generation listened either to music exclusively from their minority cultural background (including religious background) or mixture of that and Western music. The siblings of the eight boys who were the subjects of this research project tended to listen to either a similar mixture as described above, or more Western influenced music. The exception to this was given by Bartosz's mother, who did not make a distinction between the

music of Poland and of the UK, considering there to be no difference in music between the two countries (transcript parent of Bartosz line 70-73).

Questions around music and culture led to reflections from the parents that particular types of music are linked to specific cultures, but everyone enjoys music in their own way. Saif's father said that music doesn't have borders, but followed on to say that music is different in different countries and cultures (transcript parent of Saif line 101-102). Baraq's mother commented that individual preferences come before cultural considerations and that it might be useful for a music therapist to know these musical preferences and incorporate them into music therapy sessions. Parents described each member of their family as enjoying a range of different types of music according to their individual taste. The musical preferences of individuals, however, were shaped by shared experience from any or all of the various cultures and sub-cultures each of the family members discussed belonged to.

6.3.6. Religion and music

Two of the parents spoke specifically about the relation of their religion (Islam) to music. Baraq's mother talked about how her child enjoyed hearing sura, naats and nasheeds (religious chanting or recitations, the latter two sometimes accompanied by sustained drone-type notes and/or musical instruments) which she played through YouTube via her phone; she said she thought they had a relaxing or peaceful quality (transcript parent of Baraq line 60). She commented on the contrast between speaking and reciting or chanting the words of these prayers, that reciting them changes the quality of the sound; 'There's a sura that he loves, from the Qu'ran that, you know it's different when it's being recited' (transcript parent of Baraq line 179-180). Baraq's mother described these recordings to the interviewer as 'like spiritual music… religious music' (transcript parent of Baraq line 40-42) and while they are not

considered as music, Baraq's enjoyment of them was similarly expressed to that of music.

She also described how Baraq likes to listen to her pray the naats and nashids; 'He loves listening to that' (transcript parent of Baraq line 189-190), as distinct from versions on YouTube. It is probable that Baraq particularly enjoyed hearing the familiar, loved voice of his mother over a stranger's voice.

With humour in her voice Tahir's mother commented on how in Islam music, specifically music with instruments, is forbidden and considered the work of the devil, but she thought that religious music or religious poems set to music is probably acceptable, and she made the comment that music in general is often considered 'good for the soul' (transcript parent of Tahir line 92-93). Her words echoed back to the comments on the importance of recognizing individuality within a group (in this case a religious rather than ethnic or cultural group); although she was Muslim, she was also making choices about her interpretation of her religious beliefs and navigating the contradictions of her religious teachings and cultural interests and those of her family. Additionally, her description of music as good for the soul echoes the common axiom 'music is food for the soul', and while of uncertain origin is certainly well-known in Western culture; the use of this phrase in during the interview is a nod to the mixture of cultural influences to which this family is exposed, and the various levels of assimilation across the family members.

Although it did not emerge as a superordinate theme from his interview, Saif's father described how when Saif is having seizures they play religious recitations; 'if he's fitting then we, we'll play, erm, the Qu'ran. We've got that on a CD, that's our bible for Muslims' (transcript parent of Saif line 336-338). The family chose to play these recitations for the aesthetic, soothing qualities, but also quite possibly the spiritual

support that was beneficial both to Saif and his family who were caring for him through his ill health.

This superordinate theme revealed the role of music as a form that is restricted in traditional Islamic practice, but also the musical qualities of prayer and how they were used by the parents in different ways; to soothe, relax or give spiritual support. Similarly to other cultural factors, it is also highly dependent on personal interpretation and the complexities of many cultural influences being present in the home.

6.3.7. Benefits of Music Therapy

All parents made comments on this subject, thereby generating a superordinate theme, because it was one of the interview questions and a focus for the whole project. A range of benefits of music therapy were observed by the parents, for example, opportunities to practice skills such as concentration, turn-taking, making choices, and developing vocal abilities. These noted features of music therapy sessions relate closely to the kinds of benefits described by the music therapy community when working with children in special schools, such as physical and psychological stimulation, turn-taking and waiting, increased speech and eye contact, socialization, self-confidence, concentration and focus (McTier 2011 p.156). The parents noticed that in music therapy sessions the child was learning skills in a fun, exciting or motivating context; 'It's a way for them to learn different things, but in a fun way' (transcript parent of Baraq line 331-332), an approach that was essential for Bartosz; 'You can't really teach him anything if it's not through play' (transcript parent of Bartosz line 132-133).

The parents themselves enjoyed seeing their children happy so gained pleasure from the sessions themselves. Hameed's mother said, 'I enjoyed being there, seeing him

excited and being happy. So… it's like new… something new that he did, and he really enjoyed it and when he was laughing and clapping and getting excited so, made me happy to see him like that' (transcript parent of Hameed line 235-237). In watching their children in music therapy sessions, parents had an opportunity to feel pride in their child; 'I think he did really well' (transcript parent of Hameed line 228). The sessions gave the parents ideas for new ways to interact with their child at home. One of the main characteristics the parents took home was to try to follow the child's movements or sounds; to let the child lead in the interaction. Saeed's father already used music to interact with his son at home; 'we try to interest him play drum or anything else… but the thing was different is probably the way she used to follow… In Caroline's session which we didn't [do] before, try to er give [Saeed] some sort of control of the session rather than all control from the parents' (transcript parent of Saeed line 299-308). Although Tahir's mother was ambivalent about the benefits of the music therapy sessions, she had noticed the therapist's child-led approach and adopted elements of it at home; 'sometimes she [the music therapist] waited for [Tahir] to start something and she'd copy him or if she's doing, try and see if he follows her so that's the only thing we did [at home]' (transcript parent of Tahir line 230-232).

The parents found music therapy allowed the therapist to really get to know their child without need for language; especially important for those children who had little or no language so could be hard to get to know. Bartosz's mother felt her son had become more flexible in their way of engaging with the world, relating that 'Before [Bartosz] liked listening to one particular song all the time but now he's learned different patterns, different musical patterns, he's listened to different songs and sometimes he tries to copy the lyrics from songs' (transcript parent of Bartosz line 198-202). Aryan's mother commented on how the music therapy approach was able to promote her son's self-esteem 'Most of all it helped him feel good because

someone was listening to him, understanding what he was trying to communicate and, and, and giving it to him… so that must have made him feel good and it must have improved his self-esteem' (transcript parent of Aryan line 235-239). She also noted that music therapy engaged with emotions, and offered quality one to one time that was both structured and flexible, without imposing an unhelpful (although sometimes necessary) agenda on the child; 'unfortunately what tends to happen is that everyone has an agenda with these children… what I saw is it is important to keep everything aside and, you know, just, just forget about all the demands and, and relax and have some positive interaction together' (transcript parent of Aryan line 215-222).

The parents were almost wholly positive about what music therapy sessions had done for their child, with two exceptions. Tahir's mother felt that there was no real gain for her child, but that it was better than nothing and she would take up the offer of music therapy again if offered (transcript parent of Tahir line 239-240). In fact, doing no harm is an important characteristic of music therapy when working with children with disabilities; it has no harmful side effects and can be used alongside pharmacological treatments. Saeed's father felt that although music therapy sessions had been very valuable for his son, possibly providing him with rare enjoyment; 'one of the [things] he enjoyed most, one of the enjoyment in his life he really like' (transcript parent of Saeed line 333-335), it was to be described only within the realm of entertainment, not 'therapy' as no gains or improvements were to be expected; 'You know the word therapy is not the best word we can use. I'm sorry […] Because in therapy we are aiming to improve something, getting for example something better… I don't know how much [Saeed] has got any sort of, you know, treatment or because of his situation' (transcript parent of Saeed line 252-257). This parent was of course talking about his observations of own son's experience, a child who was profoundly disabled and for whom he knew only limited changes might be reasonably

expected, if any. Considering music therapy as entertainment alone removes the need for hope of future changes, something that may be very difficult for a parent to think about (this particular parent did not speak further on this subject during the interview so this conjecture does not necessarily relate to his experience).

6.3.8. The music therapy approach

Two of the parents made reference to the characteristics of music therapy as an approach. Interestingly, these parents reached different conclusions from their experiences of involvement with the project. One, Aryan's mother, was convinced of music therapy's merits as an approach to working with children with learning disabilities; structured yet flexible and positive. The other parent, Saeed's father, while expressing in strong terms his belief that his son had enjoyed the music therapy sessions, felt music therapy is a form of entertainment only and not a therapy; that no improvement or learning could be expected.

The parents, of course, were looking through the lens of their child's experience. Aryan could be observed in music therapy enjoying himself, but also engaged with the music therapist and interacting in a positive manner. Furthermore, the relationship was observed to develop over the course of the therapy and in line with the stated aims for the music therapy sessions. Saeed had much more profound disabilities and any changes were likely to be very small, and even harder to notice. Perhaps his father did not expect improvement or learning, because he knew in part how unlikely it was from a short intervention.

These two parents had a similar exposure to the music therapy approach; their children were involved in the same research project at the same school with same timescale and music therapist. They also had very similar professional backgrounds including knowledge of mental health (although further information on their

occupations is not included to protect their anonymity) and yet came to opposing conclusions about the nature of music therapy. Their different perspectives could in all likelihood be ascribed to their children's experiences in music therapy sessions; although both parents were positive about the music therapist's professional skills, Aryan clearly and actively engaged in music therapy sessions while Saeed did not to a similar extent. There is a further barrier to parents and others understanding music therapy as a form of therapy; the link with music as a form of entertainment and something very positive for children to experience in its own right prevents an understanding of its use as a therapy by a trained professional; 'Music is a powerful phenomenon as entertainment pure and simple. It is also a powerful agent within the specific context of therapy' (Ansdell 1995 p.35).

6.3.9. Emotion and personality in music therapy

While many of the parents made positive comments on the music therapist, using terms such as 'nice', 'friendly', and 'professional', Saif's father spoke in particular about the emotional and character-related qualities of the music therapist and how this had helped her to get to know his son's character and personality. He was also keen for the interviewer to know about Saif's personality; 'he's a lovely boy I don't know if you've seen the videos' (transcript parent of Saif line 149-150). These terms, such as 'passionate' and having a 'big-heart' (transcript parent of Saif line 230-234) are not necessarily used or valued in every profession, and not even in every health profession, but responding with genuine emotion and empathy is an important part of the music therapy approach.

The music therapist's personality and emotions are called into play in the music therapy room, and Saif's father particularly recognized and valued this. Furthermore, many music therapists consider using their personality and also their knowledge of their own emotional responses as a crucial tool in understanding the unfolding

dynamics and relationship in the therapy room as part of a psychoanalytically informed approach. In her work with adults with autism spectrum disorders, Saville considers psychoanalytic concepts such as transference and countertransference to be 'windows to the client's world of emotion and relationships' (2007 p.39). This reminded me of Maruf's mother commenting on how she had noticed me responding to his mood just as she sometimes did with him at home, but entirely without words, 'she could tell that he was sad, and she made a noise that, what Maruf made, and she could tell that he'd responded in the way that he could feel that she knew how he was feeling basically' (transcript parent of Maruf line 236-239).

6.3.10. Research promotes music therapy

Aryan's mother acknowledged the role this research project played in raising awareness of music therapy to parents and schools, saying, 'I think the study gives er, parents an exposure to music therapy, those who are… not heard of it before and it gives er, these children a good opportunity… or having a safe space and some expression and probably, erm, gives some exposure to the teachers as well… to think about these kinds of things in school' (transcript parent of Aryan line 352-360). Without this particular project, the likelihood was that one of the schools would never have offered music therapy, and Aryan would not have had the opportunity to have music therapy sessions.

6.4 Relating findings to research questions

The research questions for this research project are set out below. They will now be reviewed in light of the information gathered from the parent interviews.

Main research question

- What factors does a music therapist need to consider when working with a child from a cultural background other than her own?

Sub-questions

- How do culturally informed perceptions about the function of music affect music therapy work?
- Music has links with cultural identity: How does this relate to music therapy practice?

6.4.1 Main research question

What factors does a music therapist need to consider when working with a child from a cultural background other than her own?

The main research question relates to how and whether a music therapist should adapt their approach to the child they are working with in light of a perceived cultural difference between the two of them. The parents gave a number of answers that can guide a music therapist's thinking in this area, and while the parent is speaking from their own perspective rather than the child's, they are arguably best placed to understand their child's experience, especially when the child is unable to speak for themself.

Owing to the structure of this research project involving parents' attendance at music therapy sessions and the subsequent interviews, the parents were given more contact with the music therapist than might have otherwise been the case for music therapy in similar settings. It is usual, however, for most music therapists to have contact with the parent of the child they are working with, for example some music therapists are available at school parents' evenings. Other music therapists customarily work with the parent in the room, as described earlier in this chapter.

From the interviews and IPA analysis it would appear that the following are factors that a music therapist needs to consider when working with a child from a cultural background other than her own.

Working with a language barrier

Limited English did not seem to be a barrier to parents understanding the aims of the observed music therapy sessions, as demonstrated in the interviews. This could be due to the non-verbal aspects of the approach; in this setting, with these children, my music therapy approach drew heavily on patterns of early infant interaction, behaviour that is intuitive and observed in every culture.

Use of interpreters, however, while helpful in some respects was also problematic, and sometimes frustrating for both parent and interviewer. It seems that when working with limited shared language or using interpreters it is necessary to allow more time for dialogue to develop and for the music therapist to work harder to establish the relationship. This could be through further training for both interpreters and music therapists to make better use of the interpreter, and the music therapist making more conscious use of body language and non-verbal communication to connect with the parent alongside words. Where appropriate, however, either attendance of music therapy sessions or sharing video material with parents after sessions is more effective than trying to describe the sessions through an interpreter, and might be more practical in terms of time, cost and communicating the nature of music therapy more effectively.

Linguistic experiences of the child

The children in this study all experienced one or more languages in use at home in addition to English. Language was not used only for the communication of semantic

meaning; it was also used as a form of sound connection between parent and child. Saeed's family talked to him all the time to 'keep him in our family' (transcript parent of Saeed line 120-121). In speech and in singing music therapists make a vocal connection to the child that has a personal quality relating to the individual music therapist, but also qualities of rhythm and tone relating to the language of the therapist which might be a different language to that which the child is usually accustomed. It is also likely that a child from a cultural background other than the music therapist will have an additional repertoire of languages and language based patterns.

Parental involvement

The parents in this study appreciated being listened to, which is important to consider as especially as parents from minority ethnic groups sometimes have less involvement in their child's education for a number of reasons, such as language barriers, poor relationships with teachers, lower levels of engagement with the school. Parents, however, can support the music therapist in a number of ways such as through their expert knowledge of the child's unique medical, physical and communicative needs, as well as knowledge of individual preferences such as their favourite games, best times of day for music therapy sessions, and favourite instruments. Of course this would be the case for most parents of children with profound disabilities but is especially important to consider with parents from minority ethnic backgrounds because of language barriers, differences of outlook etc.

The music therapy approach of listening, following the child, engaging with sound, movement and emotion whilst having fun was one that all the parents were able to understand. They appreciated the collaborative approach and picked up ideas for home from the music therapy sessions. They also responded to the music therapist's genuine willingness to engage with the child and with them.

6.4.2 Sub questions

How do culturally informed perceptions about the function of music affect music therapy work?

Five of the families were of Muslim, Pakistani heritage. Music is forbidden in some interpretations of Islam, although all five families listened to music in different forms at home, especially if this was following their children's wishes. Several families also talked about listening to recordings of recitations of the Qur'an (called sura). Although this would not be considered music in Islam, the voices in these recordings are not using normal speech but employing a range of tones with musical qualities. The parents similarly listened to religious songs and music, naats and nashids, which employ tonal speech and also some accompaniment such as percussion or drones. These families had each found their own way of thinking about the teachings of their religion, Islam, regarding music at home and attendance of music therapy sessions for their child. Perhaps the families felt that the use of music for the benefit of their child, for therapy was a use of music that was more acceptable to them in terms of the religious teachings they followed? There may have been other Muslim families at the school who would not have agreed to take part in the research project, so I would not have had the chance to hear from them. This issue is highly significant for music therapists; music is at the core of the approach, so considering music itself to be evil or harmful inevitably means the whole approach will be unacceptable to some groups. Furthermore, this might have meant that families that could have benefitted from music therapy did not seek a referral for their child.

The restriction of the use of music due to religious teachings is a sensitive issue. It seemed in that particular British Pakistani community that children did not learn instruments due to culture rather than religion; the reason given was that it was 'un-Asian' rather than 'un-Muslim'.

Finally, many music therapists, including myself, are informed by early infant interaction. Imitating and developing vocal sounds with a child are perhaps nearer to patterns of parental interaction than what might be considered music, so this consideration might have helped the parents to consider the main focus to be on interaction and developing communication rather than music.

Music has links with cultural identity: How does this relate to music therapy practice?

A number of the parents in this study had experienced having assumptions made about them based on their cultural identity. They countered this in different ways; through upfront acknowledgement of their difference, educating others about their culture, or outright denial of any meaningful difference to majority culture in the UK. Although, as discussed in the section above music is forbidden in some interpretations of Islam, the Muslim families involved had all made an informed decision to take part in this research. Any assumption by myself that all Muslim parents would not want music therapy for their children would be incorrect and would have denied the children something the parents identified as a positive experience for them.

From discussions about the types of music listened to within family groups it was clear, unsurprisingly, that each family member had their own preferences, although these were often shaped by their cultural groups and sub-groups. The child-aged siblings of the subjects liked music from children's film and television programs, various genres of popular music, as well as listening to music from their cultural and religious background with their parents.

While undoubtedly there were at times links between the musical preferences of the subjects with their cultural background as that was the context in which they lived,

these children had a vast array of types of music available to them, partly due to technology such as YouTube. Any assumptions about musical taste based on cultural background made by a music therapist would be unlikely to match the reality. Rather, the parents asked that they (parents and children) be viewed as individuals first.

Following a music therapy session, a parent got her phone out and played me some of the naats and nasheeds she listened to with her son. I knew little about these, so she played me some different examples, including some of her and her son's favourites. In doing this she shared some aspects of her personal and cultural identity, and our relationship developed through the exchange. Starting from a position of openness and lack of expertise, especially on the part of the professional, is a very helpful way to learn about a person's music and culture and through this develop a genuine relationship with them.

6.5 Conclusion

The parents hugely valued being a part of the music therapy sessions and the research project. These parents, who are from communities who are sometimes marginalized and have fewer opportunities to have their voices heard, enjoyed involvement in the music therapy process and learned from the approach. They particularly appreciated the chance to share their opinions in the interviews and raised two main areas for consideration; the drawbacks of making assumptions about a person based on their cultural background and the challenges of building relationships without a shared language.

In this chapter I have set out the method for devising the interview schedule, administering and transcribing the interviews, and carrying out a thematic analysis using IPA. The superordinate themes have been discussed and related to the

research questions. When examining the research questions I found there were a number of factors that the music therapist needs to consider; working with multi-lingual children and parents, use of interpreters and the presence of a language barrier, the value of parental involvement for both parent and music therapist, religious and cultural restrictions around the use of music and instruments, and the parents' experiences of having assumptions made about them relating to their culture; and I have explored these themes in some detail.

Chapter seven

Discussion and conclusions

7.1 Introduction

This chapter will bring together the findings from the literature review, case studies and parent interviews and discuss them in relation to the research questions. I will then reflect on the methodology adopted, the limitations of the study and implication for future research, practice and training. I will comment on additional findings and relate my own personal experiences of doing this research project.

7.2 Discussion of findings from the literature, case studies and parent interviews in relation to the research questions.

In the literature review, case studies and parent interviews chapters, each method of enquiry was taken in turn to review how the findings contributed to answering the research questions. The first part of this chapter draws together these three discussions to bring together the findings and answer the research questions.

7.2.1 Main research question

What factors does a music therapist need to consider when working with a child from a cultural background other than her own?

There were a number of factors that a music therapist needs to consider in this context. I will now look at each of these factors.

7.2.2 Music therapist's own cultural background

Our cultural background influences virtually every aspect of how we relate to the people around us. Before a music therapist can begin to consider how their patient's cultural influences might impact upon music therapy work, they need to understand how their own worldview influences them. As a music therapist I of course include

myself in this; during the case study section of my research I examined my responses and on occasion found I was making assumptions based on some small knowledge of my subject's cultural group, for example when I incorrectly speculated that Maruf's parents did not want sessions video recorded for cultural reasons, as described in the case studies chapter, section 5.3.1. This process of self-examination for music therapists is not always a comfortable one, but helps us to gain knowledge of ourselves so we can better understand the experience of others without use of assumptions or stereotypes.

This process is particularly challenging because much of our own cultural knowledge is unconscious. Some of our emotional and behavioural responses to cultural factors are beyond both our control and our awareness, just as they are for our patients. Our cultural background, activities and values reside deep within ourselves, and influence so much of what we do, think and feel, as described by Wheeler and Baker (2010) when they reflect on the great range of factors, from childhood experiences to government policies, that influence a person's worldview (Wheeler and Baker 2010 p. 41), also cited in section 3.3.1 of this thesis. Each person has a different combination of influences; no two people are the same, although there are degrees of difference. Culture is not only connected with difference, but sameness. Cultural practices are a reflection of how people choose to share experience and belong to each other, and one of the ways in which this happens for all people is through making music together. In fact, the musics of especially diverse cultures do share limited meaning; as outlined in 3.3.6, Bright's (1993) research showed perception of both type and intensity of emotion in music are culturally specific. A number of researchers, however, found that meeting is possible through music therapy: as previously mentioned in section 3.3.6, Orth (2005) found that music could bring a diverse group of people together. Despite the culturally informed gender barrier that restricted the relationship between Zharinova-Sanderson (2004) and the male

refugee with whom she worked in Berlin, the music created a therapeutic frame within which her client was comfortable to work with her without a chaperone.

Although aspects of music in itself may be interpreted differently depending on the cultural standpoint of the participant, the means of engaging with music making and listening are common to all people: listening, watching, responding, playing and being together.

7.2.3 Parental involvement

The research design required a level of parental involvement in music therapy sessions in order for the parents to take part in the interviews. This (anticipated) variation depended on other commitments such as work or childcare. Some parents attended every session and took part in the music making, while others watched video footage of music therapy sessions. From their involvement in the sessions the parents were all able to engage with the concepts I was using, including non-verbal methods of interaction. The interviews gave them a valuable opportunity to have their voices heard, be listened to and have their opinions respected. Similarly, as part of my music therapy approach, following music therapy sessions the parents and I talked together about their child's progress; they appreciated my listening to their suggestions and then incorporating them into future music therapy sessions, a dynamic, collaborative approach that was to everyone's benefit. Baraq's mother appreciated having her opinion sought and subsequently acted on by the music therapist (6.2.2); when working with Baraq, his mother told me he liked flash cards, so I made a set (see Appendix 6) and they were subsequently used as a basis for many activities.

Many of the parents took ideas from how I interacted with their children into their own homes. For example, Tahir's mother started to incorporate child-led elements into

interactions with her son at home following observations of music therapy sessions; waiting for him to make a sound or movement then imitation him, something she had not done before (also described in section 6.2.5). Both through learning new interactive techniques and having their opinions valued and sought, the music therapy sessions played a part in empowering the parents. This particular group of parents came from minority ethnic backgrounds; groups that are often marginalized, patronized, or ignored by statutory services and society at large. Parents of disabled children already struggle with these attitudes, which are then furthered by unhelpful and inflexible systems. Collaboration through music therapy sessions and a research project went against that trend and gave an opportunity for parents to have their expertise recognized and utilized as well as developed further.

7.2.4 Subtle forms of discrimination

The discrimination experienced by ethnic minority groups comes in many forms, some extremely subtle. People who do not confirm to majority norms make many adjustments to fit in with the rest of society. People from majority culture do not experience this constant bridging of a cultural gap, so even when a person from a minority community is accessing healthcare or help of some kind, they are still bridging the gap and assisting the professional in meeting their needs, as described by Thomas and Sham (2014). They stated that 'sometimes "we don't know what we don't know" when building therapeutic relationships with patients from a different culture' (Thomas and Sham 2014 p. 90), also cited in 3.3.10. Collaborative research can help the majority in societies understand the everyday life experiences of minority communities. In particular, a variety of research methodologies that involve minority participants in different ways, such as in research design and evaluation is required, including designs such as this one that create the environment for participants to speak freely.

7.2.5 Collaboration with parents

Collaboration with parents in music therapy can be extremely useful to music therapists. Oldfield (2006) has written extensively about the benefits of working with parents (also in 6.3.3). She described how parents can offer practical support such as physical positioning of their child and medical knowledge, they can share knowledge about their child's means of interaction, and interpret sign language and other languages relating to their minority identity that may be unknown to the music therapist (Oldfield 2006 p. 113). This was the case in the clinical work connected to this research project. I was supported in such ways by the parents, who in turn benefitted from ideas they were able to take home from sessions, and greatly appreciated seeing their child enjoying positive interaction. Saeed's father thought that music therapy sessions might have been the experience Saeed had most enjoyed in his life (6.2.6). This was able to take place despite a number of cultural and language barriers. I was able to relate to the children through the non-verbal techniques used in music therapy effectively, and modeled a warm, listening, responding collaborative approach that included the parents as well.

7.2.6 How can music therapists develop their cultural competence?

The music therapy approach has certain qualities that recommend it to intercultural work: non-verbal elements, a listening, collaborative, reflexive approach. The international music therapy profession has acknowledged, however, that there is work to be done in improving music therapists' skills and knowledge when working with minorities around the world. Wheeler and Baker's (2010) survey found music therapists would have liked more space on their training courses to reflect on their own beliefs, and acknowledged particular difficulties when cultural differences existed within the clinical supervision dyad (also cited in section 3.1.1). Music therapists have recognized a need for ongoing training and CPD, as well as more

training in cross-cultural issues on music therapy courses, a finding of Toppozada's research (1995), described in 3.3.11.

Music therapy training courses around the world seem to take a range of approaches to intercultural education. Concepts originating in other fields, such as cultural empathy and cultural safety are sometimes taught. Others take a more ethnographical approach, looking at music from around the world to learn about difference in societies, but focusing on different musical characteristics. Another suggested approach is to weave cultural awareness through every part of the course; this is possibly a more practical solution for already heavily burdened programmes, and also the most authentic as culture itself is woven through all aspects of our lives, as suggested by Toppozada (1995) in 3.3.11. Stige (2002) recommended that cultural perspectives be integrated into music therapists' thinking (3.3.5). While it is certainly true that the music therapy profession in a given country may be homogenous, made up of people from relatively affluent backgrounds with few representing minorities, training courses often attract international students, creating a unique opportunity for cultural exchange. A group of music therapy trainees may provide a wealth of difference between them to explore and understand.

7.2.7 Use of supervision and personal therapy

Clinical supervision and personal therapy provide invaluable confidential spaces for music therapists to explore how their clinical work relates to their own value system, and to reflect on areas of difficulty relating to cultural differences in the therapy room. Depending on their training or orientation, music therapists might find it useful to look at approaches different to their own to broaden their music therapy perspective. Community Music Therapy places culture and context at the centre of thinking, using an ecological perspective (Stige and Aaro 2012): this was discussed in section 3.3.5. of the literature review. Psychoanalytically informed approaches provide a way to

examine unconscious responses and psychodynamics. Music therapists can also take their own steps to broaden their worldview through exposure to art and literature, awareness of history, politics and world news, and through increased diversity in their social circles. Hadley (2014) felt that music therapists must develop their understanding of their own cultural identity in both their professional and personal lives in order to work effectively in cross-cultural environments, particularly by 'breaking down white identity' (Hadley 2014 p. 222) (also cited in 3.3.10).

7.2.8 Disability and culture

It should not be assumed that when working with a person from a different cultural background that cultural issues will be present in the foreground. A person may be referred to music therapy for many reasons, and the fact that they are from a minority ethnic background might not influence the therapy. In my work with Saeed, his very significant level of disability was the central issue that limited our relationship far beyond anything else as described in the case study in section 5.2.6. I had the feeling that the daily life of the parents involved in this study was focused around the challenges of bringing up a disabled child (or children). Parents of disabled children are already in a minority of all parents; others cannot understand their experience and they can feel marginalized by a system that only really works for the majority. Parents who have another kind of difference to majority culture in addition to the needs of their child are twice marginalized.

Disability has been defined by the WHO and others as a kind of deficit within a person, usually a physical impairment (Parritt 2012 p. 30). Some people query this definition, considering disability to be a social creation; the 'disability is the difficulty experienced in accessing buildings or services, the restrictions on personal and sexual relationships, and the attitudes of a predominantly non-disabled societal structure' (Parritt 2012 p. 30). People with disabilities often share similar experiences

of marginalization or discrimination, and 'have attempted to claim a cultural identity similar to that of other oppressed people' (Parritt 2012 p. 32). McDonald et al's (2007) research explored the experiences of young people of 'multiple minority statuses', i.e. racial/cultural minority and disability, in order to gain a fuller understanding of their experience and their particular concerns (McDonald et al 2007 p. 147). People who are part of two minority groups, may find it particularly difficult to access support, overcome negative stereotypes and 'to find an accepting group' (McDonald et al 2007 p. 157).

7.2.9 Working in the home

The home is a place of safety and acceptance where a family is free to practice their cultural and religious traditions and express their values. A music therapist who comes into this environment to carry out a music therapy session is in the family's space, and must be aware; even fall in line with their customs and practices. Working in the home provides a great opportunity to see a child in their own, familiar environment, surrounded by the people, objects and practices they most closely identify with. Forrest (2014) described the experience of being immersed in the family's own culture as outlined in section 3.3.9. There is the potential for tension if the family and music therapist have difference expectations of how music therapy will take place within the home. Boundaries were an area for consideration in this respect, both in my experiences within the clinical work and in the literature review, as cultures inform many aspects of boundaries so negotiation between therapist and client may be required (Gadberry 2014), also in section 3.3.7. The idea of a protected, confidential therapy space for the patient is not a universal one. A 'communal' culture, where all of life is lived surrounded by others, or a family with a disabled child who relies on the constant presence of family members for their well-being may find this idea less relevant or helpful. A music therapist may have to reach a compromise or find an alternative way to create that safe space. For example,

when working in Saif's home the door to his bedroom, where music therapy sessions took place, was always open. My music therapy sessions generally take place behind a closed door to limit interruptions and create a quiet, private, focused space, but this did not feel appropriate in Saif's home. I found myself re-framing my boundaries with reference to the context (as described in the reflections on the case studies in section 5.3.1). I was within the safety of the family home and felt I should follow their example of keeping the door open. Keeping the door shut would not increased the experience of a safe space for Saif as he was in his home environment, although it may have made me feel more comfortable. Once I had expressed my preference of limiting visitors to the sessions (chiefly the interested family members who wanted to see what we were doing) the sessions felt peaceful, focused and contained.

7.2.10 Language and language barriers

Interestingly, some patients are able to find a safe space within their own language, speaking their troubles aloud to a therapist who cannot understand them as described by Orth (2005) and detailed in section 3.3.8. In most situations, however, it seems that language barriers are real and difficult to overcome. If either party speaks in a second language, they will most likely be limited in their expression. An interpreter can overcome some language difficulties but compromises the intimacy and safety of the therapy relationship, established by therapeutic boundaries, especially if the interpreter is known to the patient, perhaps a member of their community. Kriz and Skivenes (2010) described the potential pitfalls when using interpreters such as 'information deficits, more curtailed relationship-building processes, feelings of mistrust and practical obstacles for minority ethnic caregivers' (Kriz and Skivenes 2010 p. 1358) (also cited in 6.3.2), some of which I experienced myself through the parent interviews of Bartosz's mother (6.2.7) and Maruf's mother (6.2.4). In the research context, I found that using interpreters meant I, and my

research assistant, could not get the depth and breadth of answers possible with a shared language.

7.2.11 Music therapy can overcome barriers

The music therapists interviewed in Swinburne's (2013) research exploring the practice of a number of music therapists working in cross-cultural practice (also described in 3.3.2) suggested that in the music real 'meetings' could take place, despite significant cultural and other barriers. In improvised music, Pavlicevic (1997) felt that the therapist and client were negotiating their own culture together in the creative act of music making. Free improvised music making between two or more people offers the chance to co-create emotional expression free from rules or form, even from language, with the context of a trusting, attentive therapy relationship.

Various kinds of barriers: language, lack of self-knowledge, lack of cultural empathy; must be overcome, but are also great opportunities for music therapists to extend their ability to really listen and really meet with their patients, and to develop their understanding of the world and themselves at the same time. As music therapists we are well equipped to do this, and we should, because the people we are working with have every right to take as full a part in society as possible despite any barriers around disability or cultural difference.

7.2.12 Sub questions

Sub question one:

<u>How do culturally informed perceptions about the function of music affect music therapy work?</u>

Around the world, music is used for particular purposes; people believe music has particular functions. These functions differ between cultures, so a patient in music therapy will have particular ideas of how and why music may be used, and this may

be different to the music therapist. Awareness of a patient's viewpoint about the function of music or particular types of music, and resolution of any conflicting perceptions with the music therapist's own views of this is necessary for shared work to be possible.

7.2.13 Performance

Performance was an example cited in the literature of a practice that is perceived differently across cultures. For some societies, music is communal and always shared with other people. The idea of keeping music private is anathema; it should always be shared in performance, and both Zharinova-Sanderson (2004) and Hunt (2005) separately described this in their work with refugees in Berlin and Australia respectively, outlined in section 3.3.6. For others, making music as a group is a normal and expected part of life. It is not seen as the domain of experts alone, but for everybody. This means value judgments are not placed on it in the same way. For a person from one of these traditions, performance is not a situation of pressure and judgment, rather it is part of normal life. Orth (2005) noted mid-African refugees sang, danced and improvised more easily than those from Western cultures, and attributed this to music having a different function in those cultures, as a more integral part of life, also cited in section 3.3.6. These perspectives have an impact on the way the music therapist experiences and interprets the behaviour of their patient, perhaps incorrectly ascribing characteristics or emotions to the patient. An individual who is willing to play in front of others may not be a confidant performer; they may simply not feel a weight of expectation in the same way as someone else.

7.2.14 Religion, culture and music

Religion and culture are closely connected. Rites of passage across a lifetime, seasons and events are marked through both religious and non-religious ritual, sometimes intertwined, and many of these rituals involve music in various forms.

Some of the parents interviewed for this research commented on their Muslim faith and how Islam forbids music, including Tahir's mother in section 6.2.5. They listened to music in their homes, however; South Asian and Western popular music, and sung recitations from the Qur'an and other religious recordings with some musical qualities. Tahir's mother (at 6.2.5) also described learning instruments as 'un-Asian', and with this description placing the reasoning on cultural rather than religious grounds.

7.2.15 Building blocks of music and communication

If a particular group considers music to be forbidden, it might seem that this is a contraindication for music therapy. Of course, the parents in this study do not speak for all people who practice Islam, and this qualitative paradigm is not designed to produce widely applicable generalities. The parents were able very quickly to understand the aspects of my approach connected with early infant interaction. This made me think these building blocks of music; pitch, duration, tempo (which are also the building blocks of language) are universal; different cultural systems shape them into musical forms or styles which become culturally specific. I illustrate this in Figure 8, located on the following page.

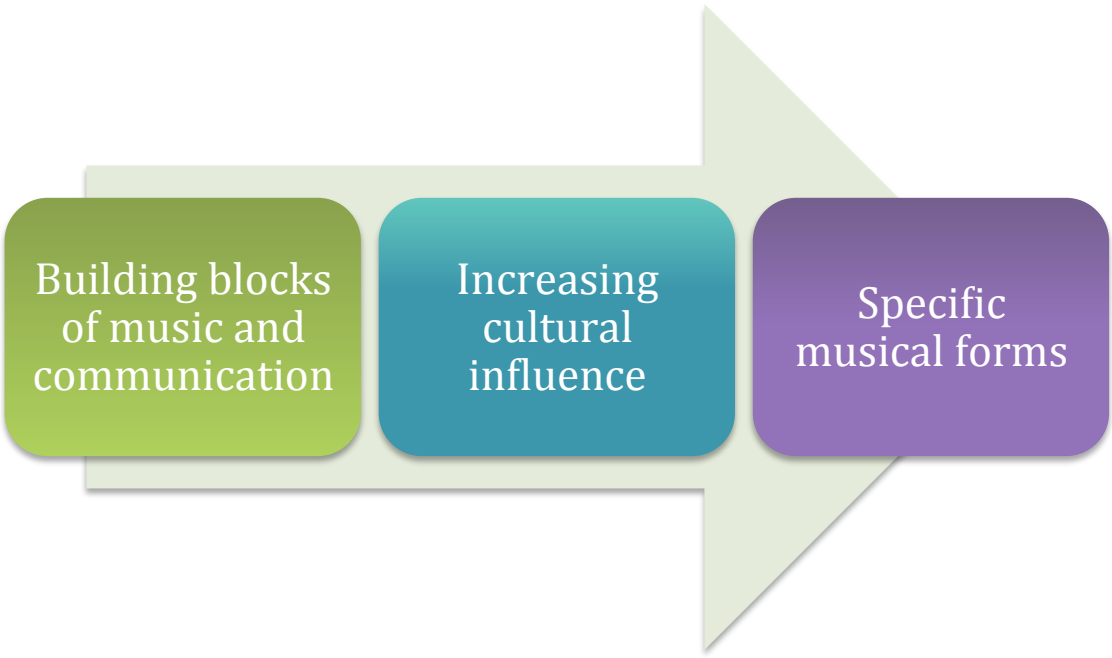


Figure 8. Cultural influence on development of music

The music I used in these music therapy sessions drew from all points on this continuum. The left hand rectangle would encompass imitation of simple sounds, as influenced by early mother-infant interaction. I began each music therapy session with a hello song which used simple tonic-dominant tonality drawn from my Western musical background and regular four bar phrases, and accompanied by a Western instrument, the guitar. I would place this song at the right hand side of the continuum. In between would be musical activities such as 'rocking' between two simple chords that could belong to a number of traditions, or pulseless vocal improvisations accompanied by a single note. (This same diagram could reflect language development, with individual phonemes on the left, and established languages on the right).

Sounds that are identifiable to patients and music therapists as culturally defined musical forms are only a part of the sounds used in music therapy sessions. Describing the music of music therapy in this way and deliberately only using sounds

on the left side of the continuum might engage parents who might not accept music therapy for cultural reasons. There are children who could benefit from the non-verbal, sound-based aspects of music therapy who might never participate because of their religious or cultural background. It is possible, however, that following some collaborative thinking with parents some compromise could be reached.

7.2.16 Music therapists' knowledge of cultural functions of music and instruments

Findings from the literature review indicated it could be useful for music therapists to learn about some of the typical functions of music in the particular cultural group of the patients they are working with. This would include knowledge of the roles of particular musical instruments within cultural practices linked to music. Baker, Jones and Day (2004) described their experiences working with young Sudanese refugees, and recounted the particular role in their culture of shakers in summoning the dead. The authors commented that knowledge of this function of their instruments in Luer culture was vital to the music therapists' practice (3.3.6). It may not always be possible for music therapists to gain such an understanding of their patients' cultural practices, depending on the circumstances. If the music therapist is running a large open group attended by many people of a diverse range of cultural backgrounds, it would be hard to find out about the many cultures represented by their group, but if they are working with a specific cultural group, for example refugees from one location, similarly to the examples given in the literature, it is more feasible. This knowledge would not be gained in order to apply wholesale to a cultural group, but to provide knowledge the music therapist may be able to draw on if necessary.

There are cultural perceptions of the use of music that it can be useful for a music therapist to learn about, if they affect their client group. This might be connected with ritualized use of particular instruments, considerations about performance or religious

teachings about certain types of music. This knowledge could be used to help develop cultural empathy; an understanding of an individual's perception of the world from their unique cultural standpoint. It might then be possible to better relate descriptions of music therapy practice to a particular cultural viewpoint.

Sub question two:

Music has links with cultural identity. How does this relate to music therapy practice?

7.2.17 A meeting of cultural identities in music therapy

The literature review demonstrated that music therapists find a shared cultural identity with their patients helpful: relationships form more quickly, and there is greater, deeper understanding between therapist and patient. This was particularly apparent in the text by Lightstone (in Hadley 2014) who felt his own Jewish identity helped him develop a deeper relationship with the elderly Jewish clients with whom he worked, as described in 3.3.4. Where cultural difference exists, relationships may take longer to form and understanding is harder to develop, as described in section 3.3.3. When music therapists tried to play the music of patients from cultural backgrounds different to their own, they found this music was experienced as inauthentic or even unintentionally comical as in Pavlicevic's (1997) example where the young people she was working with 'fell about laughing' at her efforts (Pavlicevic 1997 p. 56). One cannot assume that playing the music of a minority ethnic culture in an attempt at convergence will be effective; it might even present an additional barrier.

7.2.18 Cultural assumptions

The parents in this research project had experienced assumptions being made about them and found this to be unhelpful, stopping people from getting to know them as individuals. The parents were clear on several occasions that they wanted

themselves and their children to be treated as individuals first. Baraq's mother in particular pressed the need for the music therapist to get to know the children she works with as individuals first, saying 'you'd have to find out about each individual first, to see what kind of [music they like]' (transcript, parent of Baraq line 21-22), also discussed in section 6.2.2. The interviews showed the wide variations of musical preferences even within families, and especially between generations. These families were multicultural, with diverse interests, and had one wanted to, it would have been hard to make a correct assumption about what music a particular family member enjoyed. For most of the families in the research, the parents had been born overseas but the children were born in the UK, and they were fully immersed in British culture as well as their minority ethnic culture. Baraq's siblings listened to music from Disney's 'Frozen', English and Asian songs and Bollywood music, as may be seen in the results from the interview in section 6.2.2. The children had lived experience of two cultures; a much greater breadth of cultural knowledge than myself as the music therapist.

7.2.19 Using patients' music from their home culture in sessions

Authors such as Lang and McInerney (2002) and Orth and Verburght (1998) in section 3.3.3 also highlighted that some people from ethnic minorities want to play music from their home country to feel connected to their home culture and share this with the music therapist, while others wish to put their past behind them, either because of difficult associations or they want to embrace their new life and perhaps want to align their musical tastes to the majority (Amir 2004). Holding these considerations in mind it is advisable for a music therapist to follow their patients' lead in the use of the patients' cultural music, whilst avoiding making assumptions about the use of such music. If patients do bring such music to music therapy sessions, it can be a powerful means of experiencing and sharing culture.

7.3 Reflections on methodology

7.3.1 Structure of the project

A less conventional methodology was adopted for this research project. Usually, the research field is outlined, and then the literature review is used to determine the research focus and the gap in knowledge and construct the research questions. This project used my clinical experiences as the means to identify the focus for the study as there is very little existing research in this field. The literature review formed part of the data alongside the case studies and the interviews with parents and helped me to answer and reflect on my research questions.

This research wanted to explore the impact of cultural difference on the music therapist and patient. In this case the patients were children and young teenagers who had little or no language. To gain insight into their experience I chose to interview the people closest to them; their parents, who had also observed their music therapy sessions. As far as I have been able to investigate, this approach has not previously been used with parents within the area of music therapy and culture. Other research, however, has utilized participant interview with thematic analysis, including Interpretative Phenomenological Analysis.

This approach worked well for the subject. Treating the literature review as part of the data and applying the research questions to the findings at the end of the chapter was a logical step and it was fairly straightforward to then compare the three sets of findings derived from each of the data sources at the end in the final chapter. It could also be argued that the research methods used; interviews with Interpretative Phenomenological Analysis, the literature review and research case studies are all well known in music therapy research, as described in the methodology.

7.3.2 Use of a research assistant for interviews

In order to encourage parents to talk freely about the music therapy sessions, I employed a research assistant to administer the semi-structured interviews with parents. As I was the music therapist working with their children, I thought that it might be harder for the parents to speak critically of the music therapy session or the music therapist if I were present and therefore engaged a third party. I had selected the use of semi-structured interviews to offer some direction to the conversation but to allow the flexibility for the parents to speak at greater length or depth about a specific topic if they wanted to, or for the interviewer to question further if she felt the parent had more to say on a subject.

The use of a research assistant could therefore be seen as a limitation. However, in order to produce the research case studies I had to carry out the music therapy work. This therefore meant that it was advisable that I did not administer the interviews.

7.3.3 Amelioration of researcher bias

I employed a number of different strategies to discover and reduce researcher bias as I was both music therapist and researcher for this project. The first of these was clinical supervision. During this time I could address any concerns I had that my clinical decisions were affected in some way by my additional role as researcher, for example if I was making a decision designed to promote the research project rather than the needs of the child. At the time of the research I had been working in one of the special schools for three years, and was comfortable with the environment and my approach, so I was confident that in music therapy sessions I was able to place all my focus on the child and temporarily forget that these sessions were part of my research investigations.

In addition to supervision I used a researcher diary to record reflections relating to the clinical work that would not usually go in the clinical notes; for example observations about cultural practices, or conversations with parents about their use of music at home. I found this extremely useful; for some time before commencing my doctoral research I was interested in and had noticed how cultural background affects music therapy practice, as I relate in Chapter one with reference to music therapy related voluntary work overseas and clinical practice in multicultural settings. The researcher diary offered me a systematic approach to recording these impressions in preparation for creating the research case studies and developing my thoughts on the subject. It felt important that these observations were kept separate, as they were part of the research and not part of usual music therapy clinical notes. The researcher diary had the additional benefit that I was not restricted by the format of clinical notes: in the researcher diary I could go into as much detail as I felt necessary on a particular subject.

7.4 Additional findings

7.4.1 Awareness of own distinct approach

The dual role of researcher and clinician gave me the opportunity to look in depth at my own music therapy work, and have parents observe either music therapy sessions or video footage and give their opinions. Although daunting at times, it was a valuable experience as I learned about how the parent observers perceived my work, something I would not have experienced in my usual clinical practice.

From the parents' comments and my reflections in my researcher diary, I think my music therapy approach with these children was often characterized by warmth and humour; many of the parents used adjectives such as 'warm', 'friendly', and 'kind' to describe my manner in music therapy sessions. Saif's father commented that I was kind inside and had a big heart, as detailed in section 6.2.1. I think these

characteristics that I was able to portray helped me to build a rapport with the parents and their children, but I had not been aware of how important this empathetic stance was for the families.

In section 6.2.8 Aryan's mother commented on my calmness and wondered whether her son might enjoy higher-paced interaction as well. Her observation was accurate: I bring a calm, steady quality to music therapy sessions as part of my character, and while this suits some children I sometimes have to consciously increase the energy of my music to meet the patient. Conducting this research project helped me understand that better and as a result of this I am more attentive to responding to quicker tempi, energy levels and pacing.

7.4.2 Further valuing contact with families

I address the benefits of working with families, such as being able to draw upon their expertise concerning their child and supporting them through suggesting new styles of interaction in section 6.3.3, and before this research project had worked with family members in music therapy sessions and appreciated their involvement. Transcribing and analyzing the interviews, however, gave me a better understanding of the experiences of parents of disabled children, their struggles and preoccupations. I was particularly struck by how much it meant to them to see someone else enjoying spending time with them and appreciating their child's character. This sounds like a simple point, may of the parents specifically expressed the happiness they felt in seeing their child happy.

Since completing the clinical work and interviews I have started working in a children's hospice. The better understanding into parents' experiences and priorities gained from the research project has helped me very much in this context: I often

see children together with their families and there is an emphasis on supporting the family to spend time together enjoying each others' company.

7.5 Limitations of the study

7.5.1 Participants' involvement in research process

Effective intercultural research practices emphasize the importance of the participants from ethnic minority communities having a role in the research process, rather than being passive subjects of a research model that most likely originates in a dominant cultural system. Researchers from majority culture will not ask the right questions if they do not properly understand the issues; instead, in collaborative paradigms the questions can come from the participants. Schwantes' (2011) research with Mexican migrant farmworkers adopted Participatory Action research, with the benefit that the research paradigm itself helped to build trust and mutual respect (also described in section 3.3.12).

The semi-structured interview model provided the parents with a more flexible method of eliciting their views as the interviews gave them time to speak at length on the areas they chose. If I were to repeat the research project I would retain the semi-structured interviews but consider designing the interview schedule in collaboration with the parents. This might be possible by holding a joint meeting with the parents at each school at around the time the clinical work was beginning and encouraging some open discussion about what they felt were the key issues for them as parents of children with disabilities and from minority backgrounds, and what they would like the research to focus on. It might also be useful to have a discussion about the use of terms such as 'disability', 'ethnicity', 'culture' to find out what their preferred terms were. In Greenway school it might be possible to have the interviews administered by someone from the local British Pakistani population, as all parents were from this

community. This would not be possible in the same way at Allen school as there was a mix of cultural backgrounds.

Another means of increasing the level of participant involvement in the research process would be to have the interviewees validate the themes generated from the IPA process. I considered this possibility as I felt it would greatly enhance the results from the interviews, both in correctly identifying themes and providing feedback about which themes they would prioritise over others. After regular contact with the parents over the course of the 20 weeks of music therapy, however, I decided it would be too difficult to arrange and beyond the scope of this project. Most of the parents' attendance at music therapy sessions had been intermittent, and they were sometimes not able to communicate with me about when they might be able to attend.

It was also difficult to arrange the interviews themselves despite verbal agreements and letters (including letters translated into first languages where appropriate). There were misunderstandings, and several parents did not attend their first scheduled interview. There were a number of reasons for this, including: having to deal with sickness or a medical appointment of a family member, or organizational issues; the family member who was going to accompany the parent to the interview was suddenly not available. In light of this, and the demanding lives the parents clearly led caring for one or more disabled children, I felt I could not ask for more of their time. In retrospect, I could have at least given parents the option of greater involvement, or designed a method of validation that would not be too time-consuming for them, for example a page of Likert scales they could mark relating to each of the themes with space for comment.

The parents did, however, have an opportunity to have their voices heard in the parent interviews. There were many open questions, and some of the parents chose to speak on the subjects of music, music therapy and culture before the interviewer had asked any questions; they had clearly thought about the topic beforehand and offered their thoughts freely. They felt able to comment on personal subjects, like their religion, which indicates that they felt comfortable with the interviewer and within the agreed structure of the research project.

I could have involved more voices from minority groups in the research by including people other than parents as participants; teachers, classroom assistants or community figures. These people would have valuable insights into aspects of the experience of my subjects; lived experience of being in a minority ethnic group, knowledge of cultural interpretations or perspectives on music and its uses, disability, and health and illness. My position in each school, however, was temporary and only for the purpose of the research project. I was there as a visitor and not a member of staff. This meant I had little knowledge of the school structures and staff profile so would not have been able to identify suitable people. I was also only in the schools during the day when lessons were in progress. At this time the staff members were occupied with their duties. At both schools I got a sense that the staff group was under pressure and had little time; I would have hesitated to ask more from them for this reason. I did feel, however, that the parents were best placed to answer the questions as they knew their children better than anyone, and they had had involvement in music therapy sessions.

Another set of participants I could potentially involve were siblings. In fact, two siblings were involved in the music therapy sessions; on one occasion the younger sister of one of the research subjects attended the music therapy session with her mother because no childcare was available. This gave me an opportunity to see the

brother and sister interacting together; a different type of interaction to that with his parent. An older, adult brother (and health professional) observed the music therapy sessions of another child, and at the end of the session he and I talked about my approach and what he had noticed. These appearances of siblings were not planned but in different ways shed light on aspects of the subjects' lives. It would be difficult to formally include siblings in a research project such as this; school age siblings would be in education, older siblings in further education or work, but it could be argued that siblings would share more cultural similarities or preferences with the subjects as they were from the same generation and their perspectives are of particular interest.

McDonald et al (2007) acknowledged the complexities of research with groups with multiple, diverse needs such as those with disabilities and from minority ethnic groups. They encouraged this type of research, however, to 'contribute to a more nuanced understanding of cultural narratives and responses to oppression' (McDonald et al 2007 p. 158). Further research into this area should consider inclusion of other voices from within the schools and communities to build a greater understanding of the experiences of these children and their families.

7.5.2 Use of a research assistant to administer the semi-structured interviews

Following in-depth listening to the interview recordings I felt there were moments where the research assistant did not probe for more information at the points I would have liked to. She was, however, able to establish good relationships very quickly with all the parents, even those who seemed reluctant or with whom she was communicating via an interpreter. I did feel at times during the interviews, however, that opportunities were lost. That is not, of course, to say that I would have been able to obtain more information from the parents. The research assistant herself thought that in Bartosz's mother's interview, the parent had more to say, but the use of an

interpreter meant that it was hard to convey some of these ideas, so they did not explore them.

The research design made it essential that I was not the person administering the interviews. The research assistant had previous experience of working on research projects in a similar capacity, had some knowledge of music therapy, and she had practiced using the interview schedule on a volunteer. I felt however, that further training for the research assistant might have been useful, or that if the interviews had been administered by another music therapist, this might have enabled some parents to add to their responses.

7.5.3 Use of a contrast group

Some research paradigms might indicate the inclusion of a contrast group of subjects in the design, populated by children who fit the criteria for the research project but were of the 'same' cultural group as the researcher. I believe this would have been difficult to achieve and also add very little to the research findings.

Firstly, the idea of children who are of the 'same' cultural background as me is problematic. I do not come from the part of the UK in which the clinical work was carried out, and this is immediately apparent from my accent. In addition I was in the schools in a temporary capacity, which placed me outside the school family or culture. I felt that even if I shared white skin with some of these children, this was not enough to create similarity of cultural background; I was an outsider in many other respects.

7.6. Recommendations for future research

7.6.1 Music therapists' approaches with different types of diversity

The two schools in which I worked had different types of multiculturalism. Greenway School had a large British Pakistani population, which influenced the school's languages, clothing, cooking and music to reflect that particular community. Allen school was located in a city with many different national and ethnic influences and the school had the same character; it had an international feel rather than being influenced by one particular cultural group. My findings suggested that music therapists might be advised to learn a little about the particular culture of the person they are working with; in a school representing one cultural group this would be more possible than in a school with a more culturally diverse population. It would be interesting to consider how music therapists work in these two different types of settings; it would be more reasonable to expect a music therapists to learn about the cultural needs and preferences of a more homogenous minority group, than a setting where many culture are represented, given their time constraints.

Perhaps as part of the same piece of research, it would be interesting to elicit ethnic minority parents' views on what they value in music therapy sessions and what they expect in terms of culturally specific approaches. A design for such a piece of work should include parents as researchers in collaboration.

7.6.2 Cultural safety in research

The concept of cultural safety: ethnic minority groups identifying, planning and evaluating services for themselves, requires collaborative research models. Schwantes' (2011) mixed methods study using Participatory Action Research with Mexican migrant farmworkers, described in section 3.3.12, was an example of such a collaborative model. Truasheim's (2014) research with Torres Strait Island people, described in section 3.3.12, drew on the concept of cultural safety using qualitative

questionnaires to evaluate a music therapy pilot project. She considered that cultural safety can occur, 'when clients are able to evaluate the effectiveness of services for them through their own cultural lens' (Truasheim 2014 p. 142).

Placing this concept at the fore would be a positive step for further research in the area of cultural difference in music therapy. Greater depth of understanding, franker conversations and more detailed findings could be achieved with researchers who belonged to the communities they were researching.

The opportunities for families to collaborate in this research were limited. In a similar project I would be interested in pursuing other methods of ascertaining parents' opinions. A facilitated focus group discussion might produce potentially different data, although some parents might dominate or withdraw from the conversation, and those who did not speak English would be more challenging to include. It would be interesting to bring families together who were facing similar challenges as the process could be supportive as well as revealing new information.

7.6.3 Cultural awareness in hospice work

Hospices care for people at the end of life; a rite of passage through which every person must pass, and for which every society has its own rituals. Music therapists work with individuals and families at this time and have written about how cultural practices intertwine with their work. Forrest (2014) described cultural considerations for her home-based music therapy hospice work. She described how she conceptualizes every encounter as a cross-cultural one, bringing to play not only ethnic and national cultures, but also the family culture, sub-cultures amongst family members and the intersection with her own culture (Forrest 2014 p. 20). I now work in a children's hospice and am interested in how well these environments serve families from minority ethnic groups, especially given the role music often plays in

end of life rituals. I think there is scope for collaborative research with families from minority ethnic groups to explore these issues in this particular setting.

7.6.4 Social class and music therapy

Just as music therapists usually belong to majority culture, they are often drawn from a particular social class. Music therapy training courses require a music degree or equivalent level of musicianship, and this is usually the result of years of childhood music lessons, orchestra attendance or similar, requiring financial and time commitment. Furthermore, in order to train, students need to have significant savings or financial support, often from parents. While people of all classes may find the resources to train to be a music therapist, it seems to be the case that those with lower socio-economic status are under-represented across the profession. This is not true, however, for the patients who come to music therapy.

The conditions that connect music therapists with their patients do not discriminate by national, ethnic, cultural or class background. To promote good intercultural practice, the workforce of a service should resemble the client group it serves. This is true for intercultural work and is most likely also true of socioeconomic background. I suggest that there could be some research to see whether there is diversity across the music therapy profession in this respect, and if not, if this has an impact on clinical work. As a music therapist working in a particularly deprived area of the UK, I am very conscious of these differences and feel there might well be scope for research in this area.

7.7 Implications for future training and practice

7.7.1 Intercultural training for music therapists and students

Music therapy training courses adopt a range of approaches when educating their students about cultural difference, often with a focus on music rather than wider concepts about the experience of minority groups.

Furthermore there is little opportunity to explore cultural issues as part of formal Continuing Professional Development courses for music therapists, particularly in the UK. It would be very interesting to run training days for trainee and qualified music therapists to support them in providing good intercultural practice, then evaluate their effectiveness into whether the participants felt such training was useful to their practice and what else would be helpful in the future. Following my experiences of this research project I think this could involve:

- Workshops involving discussion with music therapists or trainees about their own beliefs and upbringing in connection with music therapy work.
- Learning around concepts such as cultural empathy, cultural safety and how minority experience differs from majority experience.
- Specific information about how different groups use music, for example different concepts of the role of performance, music in Islam. This would not be to encourage music therapist to make blanket assumptions about individuals' music-making, but to understand different philosophies.
- It would be hoped that there would be diversity within the trainers and trainees of such events.

7.7.2 Changing access routes to music therapy qualification

Music Therapy is a state registered profession in the UK, requiring a Master's degree from an approved institution. As mentioned in point 7.6.4 above, that considers social class in music therapy, one of the usual requirements is an

undergraduate degree in music, or a relevant degree with an equivalent standard of musicianship. For many, complex reasons, this seems to create more of a barrier to some than others, perhaps particularly those from minority ethnic groups and those with lower socio-economic status. Within the last year a new route has been approved into the music therapy profession in the UK; a government-backed apprenticeship (BAMT website 2019). It is possible that this will widen access to the music therapy profession, so greater diversity amongst music therapists will begin to be observed.

In their international round table presentation at the British Association for Music Therapy's 2018 conference, Hoskyns et al discussed ways to improve intercultural practice, including opening access to training courses (Hoskyns et al., 2018, p.329). Hoskyns, the programme director for music therapy at Victoria University, Wellington, described how the training course was aware that the Māori population of New Zealand was underrepresented amongst music therapists, so they changed the entrance requirements so that both halves of New Zealand's bi-cultural population could access the course.

7.8 Changing political climate

The clinical work upon which the research case studies were based took place in Autumn 2013 to Spring 2014, with the parent interviews following in Spring and early Summer of 2014. In 2016 the British people voted in a referendum to leave the European Union. Following the announcement of the referendum result, 'Ethnic minorities in Britain are facing rising and increasingly overt racism, with levels of discrimination and abuse continuing to grow' (Booth, 2019). Although the referendum did not cause racism in itself, it seemed to give legitimacy of expression to those with racist beliefs. The national poll cited in this newspaper article found '71 percent of people from ethnic minorities now report having faced racial discrimination,

compared with 58% in January 2016' (Booth 2019). Over the years since the Brexit referendum took place, British society has changed, with a greater level of hostility to those who are different.

Looking back over the interviews, I was struck with how they had taken place in a different time. For several decades it seemed as if there was an overall trend for Britain to become increasingly understanding of and open to diversity within its population, that the country was becoming more accepting of difference. I think that were I to repeat this research today, I would not be as comfortable asking such questions, and perhaps the families would be more reluctant to answer them, or even take part in the research at all.

I questioned whether the recent societal change means this research is no longer relevant. To an extent all research becomes out of date upon publication, but there has been a recent shift in British history; society's attitudes have moved in a different direction. Perhaps this research was well timed to elicit the views of these parents from minority ethnic groups at a point when they were most open, that the issues they exposed are still present but now harder for researchers to uncover.

Another way of looking at this question could be that any research raising issues regarding cultural diversity is now of crucial importance to avoid further bias and create greater understanding.

7.9 Personal journey

As may be observed from the dates above, it has taking me some years to complete this doctoral research. I had anticipated completion of this research within a three to four year timescale, but events in my personal life, in particular becoming a parent myself, increased this figure to six years. Retaining so much information over a long

period was difficult and I think this timescale also made the task of compiling it into the final thesis more challenging. The changing British climate described above made my findings from the parent interviews seem from even longer ago, but also the need to hear voices from minority groups was even greater, and I felt frustration that I was not in a position to finish it more quickly.

The arrival of my daughter meant that I temporarily lost my identity as a music therapist and researcher, and gained one of novice parent. I found myself de-skilled, cut off from my previous professional and research roles. I tried to continue to attend conferences and present papers whilst on maternity leave, keeping me in touch with my profession, but this was not easy and required considerable effort and organisation. Something I hadn't appreciated before coming a parent was how hard it would be to find the time needed to write up my research, and how much I would rely on my husband and our extended families.

Being a parent helped me to know more about the sleepless nights, the constant sense of responsibility, how much you need help from friends and family: the experiences of parenthood that only come with the arrival of your child. This experience has changed aspects of how I am as a music therapist. Daily non-verbal interaction with my own child has changed how I improvise with patients based upon this model; I take a larger part of the 'conversation' than previously and am more confident in using this language. Parents who know I am a mother seem to appreciate that I have an understanding of the daily struggles and joys of being a parent, even if I don't understand their particular circumstances of having a child with a disability.

7.10 Closing statement

On entering Greenway School I found myself surrounded by people with different coloured skin to me, wearing clothes and speaking languages from a culture different to my own. Unlike my usual experience as part of majority culture, I found myself to be different, an outsider and unfamiliar with the cultural norms of that community. This, of course, is a common experience for people from minority ethnic groups in the UK. I wondered what this meant for my practice as a music therapist. Would I still be able to develop meaningful relationships within which therapeutic change could take place? And did it matter that the means for developing these relationships, music, was a form that is so closely related to cultural background?

Taking the time to examine the issues, but more particularly speaking to parents from minority ethnic backgrounds, has shown that such families want to be treated as individuals first, but are very aware of their cultural influences and values. After the research journey I remain convinced that music therapy is a highly effective means of connecting and collaborating with children in special schools and their families from different cultural backgrounds.

References

Aasgaard, T. 2002. *Song Creations by Children with Cancer: Process and Meaning.* Aalborg: Aalborg Universitet.

Adler, N. 1997. *International dimensions of organizational behaviour.* Third Edition. Ohio: South-Western College Publishing.

Akobeng A.K., 2005. Principles of evidence based medicine. *Archives of Disease in Childhood,* 90, pp.837-840.

Amir, D. Community music therapy and the challenge of multiculturalism. In Pavlicevic, M and Ansdell, G. eds., 2004 *Community Music Therapy*. London: Jessica Kingsley Publishers. pp.249-268.

Ansdell, G.1995. *Music for life.* London: Jesssica Kingsley Publishers.

Ansdell, G. and Pavlicevic, M. 2001. *Beginning Research in the Arts Therapies : A Practical Guide*. London: Jessica Kingsley Publishers.

Aspinall, P. J. 2002. Collective terminology to describe the minority ethnic population: the persistence of confusion and ambiguity in usage. *Sociology,* 36 (4), pp.803-816.

Atkins,L. and Wallace, S. 2016.*Qualitative Research in Education*. London: Sage.

Bavington, J., 1992. The Bradford Experience. In Kareem, J. and Littlewood, R., 1992. *Intercultural therapy*. Oxford: Blackwell. pp. 113-123

Bieleninik et al. 2017. "International multicentre randomised controlled trial of improvisational music therapy for children with autism spectrum disorder: TIME-A Study." (2017). NIHR journals library

Bettany-Saltikov, J. 2012. *How to do a systematic review in nursing*. Oxford: Oxford University Press.

Blacking, J. 1987. *A commonsense view of all music: Reflections on Percy Grainger's contribution to ethnomusicology and music education.* NY: Cambridge University Press.

Blair, M. & Bourne, J.,1998. *Parental involvement in multi-ethnic schools,* London: DfES.

Booth, R., 2019. Racism rising since Brexit vote, nationwide study reveals. *The Guardian* [online] 20th May. Available at: <https://www.theguardian.com/world/2019/may/20/racism-on-the-rise-since-brexit-vote-nationwide-study-reveals>
[Accessed 12th July 2019].

Bradt, J.1997 Ethical issues in multicultural counseling: implications for the field of music therapy.*The arts in psychotherapy,* 24 (2), pp.137-143.

Bradt, J. Burns, D. and Cresswell, J., 2013. Mixed Methods Research in Music therapy research. *Journal of Music Therapy,* 50, 2, pp.123-48.

Bright, R. 1993. Cultural Aspects of Music in Therapy. In Heal, M. and Wigram, T., eds. *Music therapy in health and education.* London: Jessica Kingsley Publishers, pp. 193-207

British Association for Music Therapy 2014. Private email correspondence between British Association for Music Therapy and author, October 2014.

British Association for Music Therapy 2019, Arts therapist – approved for delivery [online] Available at https://www.bamt.org/DB/news-2/arts-therapist-approved-for-delivery.html [accessed 23 July 2019].

Broomfield, A. 2004. *All Our Children Belong: Exploring the experiences of black and minority ethnic parents of disabled children*. London: Parents for Inclusion.

Brown, J. 2002. Towards a Culturally Centered Music Therapy Practice. *Voices: A World Forum for Music Therapy*, *2*(1). https://doi.org/10.15845/voices.v2i1.72

van Bruggen-Rufi, M., Vink, A., Achterberg, W. and Roos, R. 2017. Improving quality of life in patients with Huntington's disease through music therapy: A qualitative explorative study using focus group discussions. *Nordic journal of music therapy* vol 27, 2018, issue 1. pp. 44-66 https://doi.org/10.1080/08098131.2017.1284888

Bryman, A. 2008. *Social Research Methods third edition*. Oxford: Oxford University Press.

Carr R, Whiteson M, Edwards M, Morgan S. 2013. Young adult cancer services in the UK: the journey to a national network. *Clin Med (Lond)*. 2013;13(3):258-262. doi:10.7861/clinmedicine.13-3-258

Chan, G. 2014. Cross-cultural music therapy in community aged care: A case vignette of a CALD woman. *Australian Journal of Music Therapy,* 25, pp.92-102.

Chapman, S., McNeill, P. & Mcneill, P., 2005. *Research Methods.* Abingdon: Routledge.

Chase, K. M. 2003. Multicultural Music Therapy: A Review of Literature. *Music Therapy Perspectives*, Volume 21, Issue 2, 2003, Pages 84–88, https://doi.org/10.1093/mtp/21.2.84

Dhillon-Stevens, H. 2012a. Race, Culture and Ethnicity. In Feltham, C. and Horton, I. eds.,*The Sage Handbook of Counselling and Psychotherapy.* Third Edition. London: Sage. pp. 54-61

Dhillon-Stevens, H. 2012b. Working with Race, Culture and Ethnicity. In Feltham, C. and Horton, I. eds.,*The Sage Handbook of Counselling and Psychotherapy.* Third Edition. London: Sage. pp. 641-649

Doktor, D. 2016. Intercultural good practice guidelines. In Dokter, D. and Hills de Zárate, M., eds., *Intercultural arts therapies research: issues and methodologies*. Abingdon: Routledge. pp. 93-110

Drake, T. 2011. Becoming in tune: the use of music therapy to assist the developing bond between traumatized children and their new adoptive parents. In Edwards, J. ed. *Music therapy and parent-infant bonding* Oxford: Oxford University Press, pp. 22-41.

Ettenberger, Mark et al. 2017. "Family-Centred Music Therapy with Preterm Infants and Their Parents in the Neonatal Intensive Care Unit (NICU) in Colombia - A Mixed-Methods Study." *Nordic Journal of Music Therapy* 26.3 (2017): pp. 207–234.
Forrest, L. 2014. Your song, my song, our song: developing music therapy programs for a culturally diverse community in home-based paediatric palliative care. *Australian Journal of Music Therapy* 25, 2014, pp.15-27.

Frederickson, N. and Cline, T. 2002. *Special educational needs inclusion and diversity: a textbook*. Buckingham: Open University Press.

Freitas, C. and Martin, G. 2015. Inclusive participation in health: policy, practice and theoretical contributions to promote the involvement of marginalised groups in healthcare. *Social science and medicine,* 135, pp.31-39.

Fugard, A., Kani, J. and Nshona, W. 1972. *Sizwe Banzi is Dead*. [An Eclipse Theatre/Young Vic Co-production 2014].

Gadberry, A. 2014. Cross-cultural perspective: a thematic analysis of a music therapist's experience providing treatment in a foreign country. *Australian Journal of Music Therapy,* 25, pp.66-80.

Gans, E. 2007. White guilt, past and future. *Anthropoetics - The Journal of Generative Anthropology,* XII, 2 (Fall 2006/Winter 2007) http://www.anthropoetics.ucla.edu/ap1202/wg.htm Accessed 8th June 2014.

Gregory, A. H. 1997. The roles of music in society: the ethnomusicological perspectice. In Hargreaves, D. and North, A. eds., *The social psychology of music.* Oxford: Oxford University Press. pp.123-40.

Hadley, S. 2014. *Experiencing race as a music therapist: personal narratives.* University Park, Illinois: Barcelona Publishers.

Hanser, S. and Wheeler, B. 2005 Experimental Research. In Wheeler, B. ed. *Music therapy research.* Second Edition. Gilsum, N.H.: Barcelona Publishers, pp.261-271.

Harris, A. and Goodall, J. 2008 Do parents know they matter? Engaging all parents in learning. *Educational Research.* 50, 3, pp.277-289.

Health and Care Professions Council 2013. *Standards of proficiency: arts therapists*. http://www.hpc-uk.org/assets/documents/100004FBStandards_of_Proficiency_Arts_Therapists.pdf Accessed 8th June 2014.

Hoskyns, S. et al, 2018. Unsettling ourselves and working with what we cannot explain in intercultural practice in music therapy: different worldviews of health. In Warner, C., Tsiris, G. and Watson, T. eds. *Music Diversity and Wholeness: London 2018.* Book of abstracts for third BAMT conference 16th-18th February p.329.

Hunt, M. 2005. Action research and music therapy: group music therapy with young refugees in a school community. *Voices: a world forum for music therapy,* 5 (2). doi: 10.15845/voices.v5i2.223

Ip-Winfield, V., Wen, Y. and Yuan, C. 2014. Home-based music therapy for the aged Chinese community in Melbourne: challenges and outcomes. *Australian Journal of Music Therapy,* 25, pp.122-134.

Jacobsen, S.L. 2009. Music therapy with children and their families. *Nordic Journal of Music Therapy,* 18 (2), p.189.

Jones, C., Baker, F and Day, T. 2004. From healing rituals to music therapy: bridging the cultural divide between therapist and young Sudanese refugees. *The Arts in Psychotherapy,* 31, pp.89-100.

Kaenampornpan, P. 2015. *The inclusion of the family members as primary carers in music therapy sessions with children in a special education centre: How does this help the child and the carer?* Doctoral thesis, Cambridge: Anglia Ruskin University.

Kareem, J. and Littlewood, R.1992. *Intercultural therapy*. Oxford: Blackwell.

Kim, S-A and Elefant, C. Multicultural considerations in music therapy research. In Wheeler (Ed.). 2016. *Music Therapy Research*. Third edition. New Braunfels : Barcelona Publishers. pp. 187-204

Kriz, K and Skivenes, M. 2010. Lost in Translation: how child welfare workers in Norway and England experience language difficulties when working with minority ethnic families. *British Journal of Social Work,* 40, pp.1353-1367.

Lang, L. and McInerney, U. 2002. Bosnia-Herzegovina: a music therapy service in a post-war environment. In Sutton, J. ed., *Music, music therapy and trauma: International perspectives*. London: Jessica Kingsley Publishers, pp.231-259.

Letwin, L and Silverman, M.J. 2017. No between-group difference but tendencies for patient support: A pilot study of a resilience-focused music therapy protocol for adults on a medical oncology/hematology unit. *The Arts in Psychotherapy.* Volume 55, September 2017, pp. 116-125 DOI: https://doi.org/10.1016/j.aip.2017.06.002

Lightstone, A. and Hadley, S., 2013. Reflections on the complexities and paradoxes of identity. in Hadley, S. *Experiencing race as a music therapist.* University Park, Illinois: Barcelona Publishers, pp.29-41.

Littlewood, R., 1992. How universal is something we can call 'therapy'?. In Kareem, J. and Littlewood, R., 1992. *Intercultural therapy*. Oxford: Blackwell. pp. 39-58

Loth, H. 2014. *An investigation into the relevance of gamelan music to the practice of music therapy.* Doctoral thesis, Cambridge: Anglia Ruskin University.

Mathieson, C.M. and Stam, H. J. 1995. Renegotiating identity: cancer narratives. *Sociology of Health & Illness*, 1995-6, Vol.17 (3), pp. 283-306

Matsumoto, D. 1996. *Culture and Psychology.* Pacific Grove, CA: Brooks/Cole.

McDonald, K.E., Keys, C.B. and Balcazar, F. 2007. Disability, race/ethnicity and gender: themes of cultural oppression, acts of individual resistance. *American*

Journal of Community Psychology (Online). Macon Vol. 39, Iss 1-2 Mar 2007 pp. 145-161 DOI:10.1007/s10464-007-9094-3

McTier, I.S. 2011. Music therapy in a special school for children with autistic spectrum disorder, focusing particularly on the use of the double bass. In Tomlinson, J., Derrington P. and Oldfield A. eds., *Music Therapy in Schools: Working with Children of all Ages in Mainstream and Special Education.* London: Jessica Kingsley Publishers, pp.150-163.

Moreno, J. 1988. Multicultural music therapy: the world music connections. *Journal of Music Therapy,* 25 (1), pp.17-27.

Murphy, K.M., Wheeler, B.L. and Murphy, K.M. 2016. *Music therapy research.* Third edition. New Braunfels : Barcelona Publishers.

Navarro Wagner, A. 2015. The art of re-framing. *Voices: a world forum for music therapy,* 15, 1.

Office for National Statistics 2018
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/bulletins/ukpopulationbycountryofbirthandnationality/2017

O'Grady, L. & McFerran, K. 2007. Community Music Therapy and Its Relationship to Community Music: Where Does It End?, *Nordic Journal of Music Therapy*, 16:1, pp. 14-26. DOI: 10.1080/08098130709478170.

Oldfield, A. Flower, C. and Hesketh, V. 2008. *Music therapy with children and their families.* London: Jessica Kingsley Publishers.

Orth, J. (2005) Music therapy with traumatized refugees in a clinical setting. *Voices: a world forum for music therapy,* 5, 2.

Orth, J. and Verburght, J. 1998. One step beyond: music therapy with traumatised refugees in a psychiatric clinic. In D. Doktor *Arts therapists, refugees and migrants: reaching across borders.* London: Jessica Kingsley Publishers. pp. 80-93

Page, J. Whitting G. and Mclean C. 2007. *Engaging effectively with black and minority ethnic parents in children's and parental services*. London: DfCSF.

Parritt, S. Disability. 2012. In Feltham, C. and Horton, I. eds., *The Sage Handbook of Counselling and Psychotherapy.* Third Edition. London: Sage. pp. 30-33

Pavlicevic, M. 1997. Culture, cross-culture and multi-culture. *British Journal of Music Therapy* ,11 (2). p. 56

Quin, A. and Rowland, C. 2016. Intercultural skill-sharing in music therapy. In Dokter, D. and Hills de Zárate, M. eds., *Intercultural arts therapies research: issues and methodologies*. Abingdon: Routledge, pp.111-130.

Rice, T. 2014. *Ethnomusicology: A very short introduction*. US: Oxford University Press

Ryde, J. 2009. *Being white in the helping professions: developing effective intercultural awareness.* London: Jessica Kingsley Publishers.

Saggers, S., Walter, M., and Gray, D. 2011. Culture, history, and health. In Thackrah, R. and and Scott, K. eds., *Indigenous Australian health and culture: An introduction for health professionals.* Sydney: Pearson Australia, pp.1-21.

Saville, R, 2007. Music therapy and autism spectrum disorder. In Watson, T. ed., *Music therapy with adults with learning disabilities.* Hove: Routledge, pp.33-46.

Schmid, W et al. 2018. "Patient's and Health Care Provider's Perspectives on Music Therapy in Palliative Care - an Integrative Review." *BMC palliative care* 17.1 (2018): pp. 32–9.

Schwantes, M. 2011. *Music therapy's effects on Mexican migrant farmworkers' levels of depression, anxiety and social isolation: a mixed methods randomized control trial utilizing participatory action research*. Aalborg: Aalborg Universitet.

Shein, E. 1984. Coming to a new awareness of organizational culture. *Sloan management review,* 25 (2), pp.3-16.

Shoemark, H. 2014 Regarding culture and music therapy [online]. Australian Journal of Music Therapy, 25, [1]-[2]. Availability: <http://search.informit.com.au/documentSummary;dn=472480382609908;res=IELHEA> ISSN: 1036-9457. [accessed 22 Jun 15].

Silverman, M. J. (2019). Quantitative comparison of group-based music therapy experiences in an acute care adult mental health setting: A four-group cluster-randomized study, *Nordic Journal of Music Therapy*, 28:1, 41-59, DOI: 10.1080/08098131.2018.1542614

Smeijsters, H. and Aasgaard, T. 2005. Qualitative case study research. In Wheeler, B. ed., *Music therapy research.* Second Edition. Gilsum, N.H. : Barcelona Publishers. pp. 440-457

Smith, J., Flowers, F. and Larkin, M. 2009. *Interpretative Phenomenological Analysis: theory, method and research.* London: Sage.

The Society for Ethnomusicology. 2020. *About ethnomusicology*. https://www.ethnomusicology.org/page/AboutEthnomusicol [Accessed 09.07.2020]

Stern, D. 1985. *The interpersonal world of the infant: a view from psychoanalysis and developmental psychology.* London: Karnac.

Stige, B. 2002. *Culture-centered music therapy*. Gilsum, N.H.: Barcelona Publishers.

Stige, B. and Aaro, L.E. 2012. *Invitation to community music therapy.* Abingdon: Routledge.

Swinburne, C. 2013. *Music therapy and cultural identity: an exploration of meetings between music therapists and clients from different cultural backgrounds.* Unpublished MA thesis, Cambridge: Anglia Ruskin University.

Thomas, A and Tsz Ying Sham, F. 2014. “Hidden Rules”: a duo-ethnological approach to explore the impact of culture on clinical practice. *Australian Journal of Music Therapy,* 25, pp.81-91.

Toppozada, M.R. 1995. Multicultural training for music therapists: an examination of current issues based on a national survey of professional music therapists. *Journal of Music Therapy* XXXII (2), pp.65-90.

Truasheim, S. 2014. Cultural safety for Aboriginal and Torres Strait Islanders within Australian music therapy practices. *Australian Journal of Music Therapy*, 25, pp.135-147.

Tyler, E. B. 1871/1958. *The origins of culture* (Part I of *Primitive Culture*.) New York: Harper and Row.

Valentino, R. E. 2006. Attitudes towards cross-cultural empathy in music therapy. *Music Therapy Perspectives,* 24, 2. pp. 108-114

Watson, T. 2007. *Music therapy with adults with learning disabilities.* Hove: Routledge.

Wheeler, B. 2005. *Music therapy research.* Second Edition. Gilsum, N.H.: Barcelona Publishers.

Wheeler, B. and Baker, F. 2010. Influences of music therapists’ worldviews on work in different countries. *The Arts in Psychotherapy,* 37, pp.215-227.

Wigram, T., Pedersen, I. N. and Ole Bonde, L. 2002. *Comprehensive Guide to Music Therapy: Theory, clinical practice, research and training.* London: Jessica Kingsley Publishers.

Wigram, T 2004. *Improvisation: methods and techniques for music therapy clinicians, educators and students.* London: Jessica Kingsley Publishers.

Williamson et al. 2010. Adolescents’ and parents’ experiences of managing the psychosocial impact of appearance change during cancer treatment. *Journal of Pediatric Oncology Nursing* 27(3) pp. 168-175

Yehuda, N. 2002. Multicultural encounters in music therapy – a qualitative research. *Voices: a world forum for music therapy, 2 (3).*

Zharinova-Sanderson, O. 2004. Promoting integration and socio-cultural change: community music therapy with traumatised refugees in Berlin. In Pavlicevic, M. and Ansdell, G. eds., *Community Music Therapy.* London: Jessica Kingsley Publishers. pp. 233-248

Appendix one: Participant information form (parent)

Anglia Ruskin University
Cambridge & Chelmsford

Cambridge Campus
East Road
Cambridge
CB1 1PT

T: 0845 271 3333
Int: +44 (0)1223 363271
www.anglia.ac.uk

Participant Information Sheet

Research Project: Intercultural Music Therapy

I would like to invite you and your child to participate in a music therapy research project.

The purpose of this project is to explore issues in music therapy between people of different cultural backgrounds. For example, in some countries the drum is the most important instrument, and the music therapist might consider this when working with someone from that culture. This research should help music therapists in the future to think about how they work with people with different cultural backgrounds to themselves.

This project forms part of my doctoral research at Anglia Ruskin University. Once the music therapy sessions and interviews have taken place, they will be analysed, written about and then submitted to the university and published in the public domain.

This study is being funded by the researcher, so the music therapy sessions are offered to the school free of charge. If you would like further information, or have questions, you can contact Caroline Anderson, the researcher at caroline.anderson@student.anglia.ac.uk, 07776 140 466 or arrange to meet her at the school.

Your child's participation

Your child has been invited to take part in the study because they come from a different cultural background to the music therapist. You can refuse for them to take part. You can withdraw your child from the study at any time by contacting Caroline Anderson or the school. After publication, it will no longer be possible to withdraw.

Music therapy sessions are run by a trained, qualified music therapist and involve the use of live, improvised music to develop, for example, communication and self-expression. If you agree to take part in the study, your child will have weekly music therapy sessions for up to two terms. You are invited to attend all or some of your child's music therapy sessions, and once these have ended you will be interviewed about what you thought about the music therapy. This interview should take 45 minutes to 1 hour. The music therapy sessions will be videoed, and the interviews will be audio-recorded. The names of you and your child, and the location of the school and any other identifying details will be concealed; every effort will be made to maintain your anonymity.

There are no known risks from taking part in music therapy sessions; music therapists are commonly employed in special schools and have specialist training to work with these pupils. A qualified, state registered music therapist will run the sessions. They will be supervised by an experienced music therapist, have insurance and CRB checks in line with school policy.

YOU WILL BE GIVEN A COPY OF THIS INFORMATION TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM

Appendix two: Participant information form (child)

Participant Information Sheet: Children

Anglia Ruskin University
Cambridge & Chelmsford

Cambridge Campus
East Road
Cambridge
CB1 1PT

T: 0845 271 3333
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www.anglia.ac.uk

Information sheet

music therapy project

You are invited to take part in music therapy sessions.

We will meet once a week for two terms.

We will play musical instruments ...

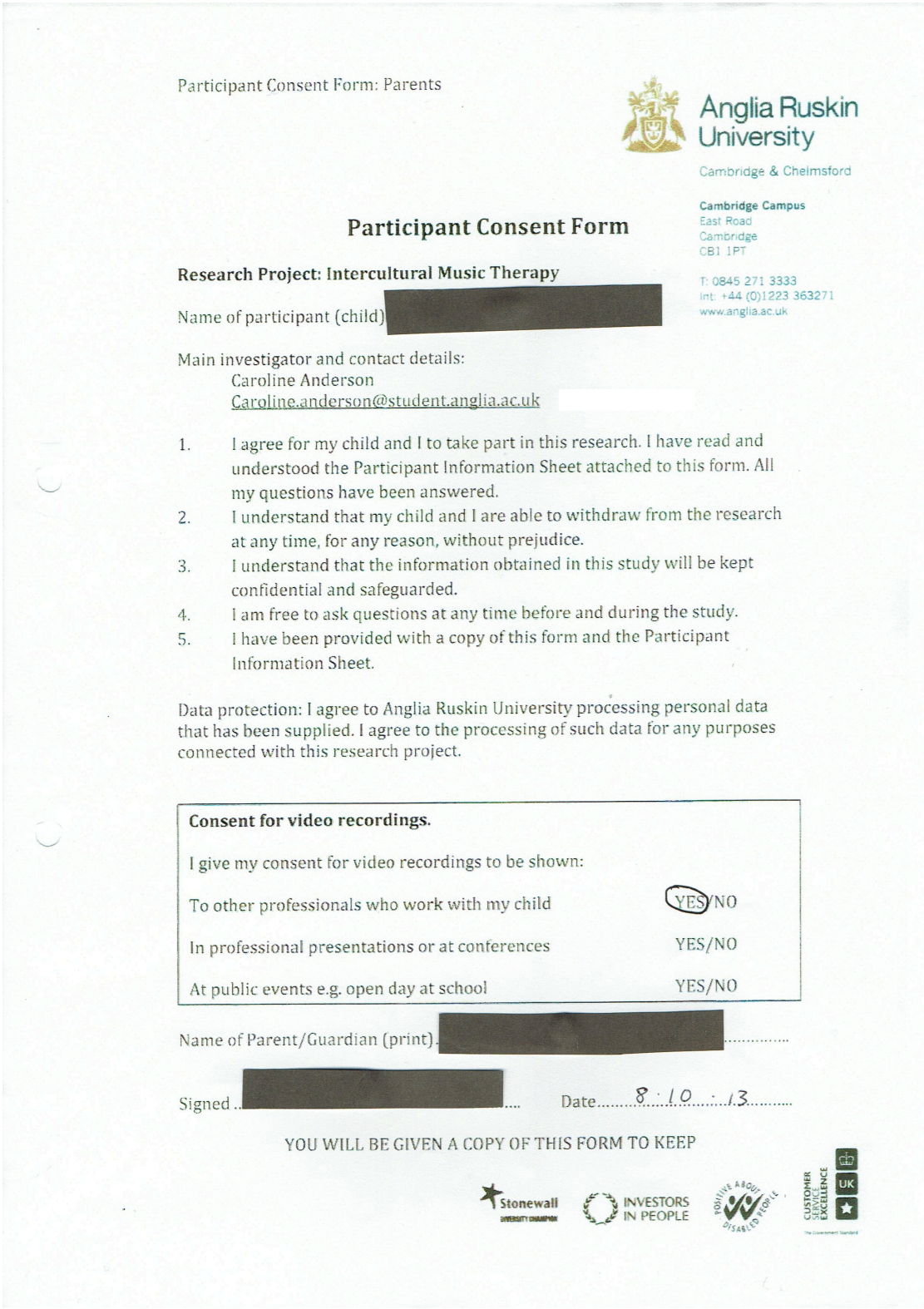
sing, and play musical games...

The music therapy sessions will be videoed.

Thinking about these sessions will help us to know about how music therapy might help other children.

If you would like to come to music therapy, please sign the consent form. If you have any questions, you can ask Caroline (the music therapist) or your teacher.

Appendix three: Consent form (parent)



Participant Consent Form: Parents

Anglia Ruskin University
Cambridge & Chelmsford

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East Road
Cambridge
CB1 1PT

T: 0845 271 3333
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www.anglia.ac.uk

Participant Consent Form

Research Project: Intercultural Music Therapy

Name of participant (child) [redacted]

Main investigator and contact details:
Caroline Anderson
Caroline.anderson@student.anglia.ac.uk

1. I agree for my child and I to take part in this research. I have read and understood the Participant Information Sheet attached to this form. All my questions have been answered.
2. I understand that my child and I are able to withdraw from the research at any time, for any reason, without prejudice.
3. I understand that the information obtained in this study will be kept confidential and safeguarded.
4. I am free to ask questions at any time before and during the study.
5. I have been provided with a copy of this form and the Participant Information Sheet.

Data protection: I agree to Anglia Ruskin University processing personal data that has been supplied. I agree to the processing of such data for any purposes connected with this research project.

Consent for video recordings.

I give my consent for video recordings to be shown:

To other professionals who work with my child	YES/NO
In professional presentations or at conferences	YES/NO
At public events e.g. open day at school	YES/NO

Name of Parent/Guardian (print) [redacted]

Signed [redacted] Date 8.10.13

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

Stonewall DIVERSITY CHAMPION · INVESTORS IN PEOPLE · POSITIVE ABOUT DISABLED PEOPLE · CUSTOMER SERVICE EXCELLENCE UK

Appendix four: Consent form (child)

Participant Information Sheet: Children

Anglia Ruskin University
Cambridge & Chelmsford

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www.anglia.ac.uk

Information sheet

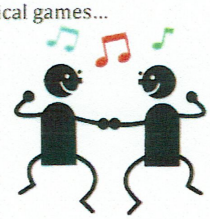
music therapy project

You are invited to take part in music therapy sessions.

We will meet once a week for two terms.

We will play musical instruments ...

sing, and play musical games...



The music therapy sessions will be videoed.

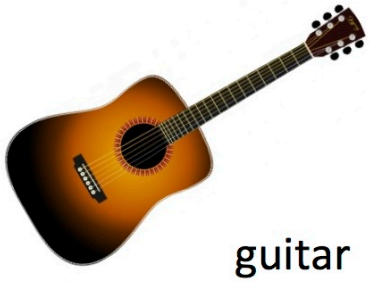
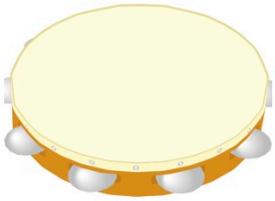
Thinking about these sessions will help us to know about how music therapy might help other children.

If you would like to come to music therapy, please sign the consent form. If you have any questions, you can ask Caroline (the music therapist) or your teacher.

Appendix five: Literature review organization table example

Amir, D. (2004). 'Community music therapy and the challenge of multiculturalism'. In Pavlicevic, M and Ansdell, G. eds. *Community Music Therapy*. London: Jessica Kingsley Publishers. Chapter 12 pp. 249-268 -Taking MT into the community helps MT consider clients as cultural as well as musical beings -Some clients want to remember home culture, others want to 'fit in'. Personal variation	MT & C
Bradt 1997 'Ethical issues in Multicultural counseling: implications for the field of MT' In *The arts in psychotherapy* 24 (2) pp 137-143 - Imposing Western music of our clients – communicating 'musical superiority'? - Mis-diagnosis due to cultural difference; Hispanic client's loud fast playing was sign of distress, not issues of self-control p142	Training and practice
Bright, R 1993 'Cultural aspects of music in therapy' in Heal and Wigram, eds. *Music therapy in health and education* p193-207 - Played excerpts of Asian music (with Asian agreed predominant emotion) to European people – they experienced the emotions differently	M & C
Dokter 1998 *Arts therapists, refugees and migrants* London: JKP - clash when people from 'we' culture or 'collective' culture asked about individual roles and feelings o Need to preserve face and family honour o Not acceptable to discuss with outsiders	AT & C
Forinash, M (1990) *A phenomenology of music therapy with the terminally ill*. New York University - Phenomenology is… 'method of research which would allow for an in depth exploration without compromising the phenomenon' - Acknowledging the complexity of the therapeutic event… and maintaining it's wholeness and integrity in the research process p.1	MT & C

Appendix six: Musical instrument flash cards

 guitar	 djembe
 piano	 tambourine
 maracas	 ocean drum
 tambourine stick	 indian bells

Interview Schedule

Topic: Cultural and ethnic identity

Issue/topic	Possible questions	Possible follow up questions	Probes
Cultural/ ethnic identity	Could you describe the cultural/ethnic influences on your, and your family's background? ...However you wish to do so. How many generations of your family have lived in the UK, in this local area? Could you tell me about the groups of people you socialize/spend time with? Could you tell me about music within your cultural heritage? Do you play a musical instrument or sing?	What are your strongest influences? What is most important to you? Would you say this the same for other family members? Do you have friends/family/acquaintances with whom you share this identity Are any of them linked to you by ethnicity/culture/religion? Do you participate in e.g. cultural events/activities connected with the cultural group(s) you feel you belong to? The different ways it is used? With dance, drama? Who by? Within different groups? For what purposes?	Tell me more about that Go on Anyone else?

Topic: Home life, participation in this research project

Issue/Topic	Possible questions	Possible follow up questions	Probes
Home life	What are the sounds you might find in your house? Which languages do you speak? Some questions about your son (who has been attending MT): How do you interact with your child?	Music played, radio, TV, DVDs? Any other music, dance, film? With whom do you use these languages? What languages do you speak with him? What does he listen to/watch at home? What's his favourite? Talking? Singing songs? Games?	Could you give examples? Could you say more about that? How has that come about? And...
This research project	How have you found the experience for you and your child of being involved in this research project? How did you find coming into school to see your child?	Were you able to attend MT sessions with your child? If not, why, if so, how was that? How much involvement do you have at school?	[Silence]...?

Topic: Music Therapy

Issue/Topic	Possible questions	Possible follow-up questions	Prompts
Music therapy	What's your understanding of the music therapy sessions?	What do you think your son got out of sessions? What did you get out of them?	Can you tell me more about that?
	Had you any prior knowledge of MT?	What were the circumstances?	
	What did you think of the music therapy sessions?	What did you think about the music therapist's approach? About how she used music for general therapy aims? Did you think it was useful/effective?	Could you comment further?
		The use of the voice, the instruments, waiting and silence?	
	What did you think about the therapist?	Her manner, presentation, clothing. The instruments, songs used, kinds of music	
	Could the therapist have done anything to put you more at ease?	Would you have preferred if she were male? If she had been of a cultural background closer to your own? Would you have preferred not to have been there?	
	Do you think the music therapy process has changed how you use music with your child?	Have you used anything you saw in music therapy sessions at home?	
	Would you use music therapy in the future if it were available?		

Appendix eight: Transcript example

Greenway School Interview - Father of Saif

Interview transcript	Notes
I: Hello, thank you for coming to the interview. My name's Michelle and I'm the research assistant for this research project	*P continually interrupts I, sounds a little impatient.*
P: Hi Michelle	
I: I'm not a music therapist, but I have some knowledge of music therapy. I'm actually a speech therapist by training	
P: OK	
I: So… this interview is being recorded	
P: Sure	
I: But every effort will be made to maintain your anonymity, so the names of you and your child…	
P: OK	
I: …and the location of the school and any other identifying details will be concealed. OK?	
P: OK	
I: So this research project is exploring the subject of cultural differences between music therapist and client	
P: OK	
I: So what difference this makes, if any, how music therapists should think about this issue, and links between music, culture and therapy. So I'm now going to ask you some questions…	
P: Sure	
I: …about your own cultural background and that of your family, the place of music in your home…	
P: Sure	*P seems to be listening a little more now, but still interrupting*
I: … and your experience of music therapy sessions. Erm I will ask you about your experience of being part of this research project as well. Please answer as fully as you can. Erm, if you need any clarification please do ask	
P: OK	
I: …and feel free not to answer any of the questions if you prefer not to do so	
P: No problem	
I: All right	
I: OK, so if we start with a bit about yourself and your background. Could you describe your cultural and ethnic influences for you and your family?	
P: Do you want my background first then	'Born and bred' – similar language used a couple of times. Defensively?
I: However you wish to do so…	
P: So I'm British Asian	
I: Yeah	
P: I was born and bred here. My parents come from Pakistan, so it's British Asian Pakistani	
I: OK	
P: if you want my ethnicity. OK. What was the other question, sorry?	

I: Any influences, like the strongest influences in your… P: Well obviously we're British, and my parents come from Pakistan, so it's diverse, it's British and it's Pakistani culture, er and that reflects in the music as well. It's Western and south Asian I: Yeah. Lovely. So how many, erm, generations of your family live here, and how many are still in Pakistan P: So, erm, roughly my grandfather came over in the fities. He was in the British army I: OK P: Erm… my father came over, I think he was fifteen or sixteen I: Ah OK P: And he came over and he worked in the woolen industry that was quite prevalent then I: Oh right. Interesting P: ..locally… erm so, so yeah. Obviously me and my brothers and sisters were born here I: Have you got a lot of brothers and sisters P: Yes, there's eight of us all together I: Wow! P: So I: And do they all live locally P: They all live locally, yes I: To here? P: Yes I: Lovely P: So I: And how many children do you have? P: I have five I: Five P: Two that are able; a twenty year old son that's at Bradford University and a ten year old girl that goes to a local school just down the road, C++++ Lane. And then there's [Saif], who's obviously here now, 14, that's had the music therapy. And my daughter, she's nine, she's here, and another son who's six that comes to this school. So… {3.15} I: OK P: …three disabled children that come to this school I: Right so you know the school quite well then I imagine P: Very well, very well. [A] has had music therapy before in hospital I: Oh right? P: And we were quite familiar with what the offer was and… so that's why we jumped at the chance when Caroline offered so… I: Oh lovely, so you've had some previous experience P: yes. [A] enjoys it so… it was good I: And so what is your understanding of music	*P has much gentler, more friendly tone now* Communicating challenges of life with three disabled children at home Some contradictions in this – music has no boarder, but also clearly links to particular cultural/ethnic distinctions Then talks about [A]'s personal relationship with music – all musics

therapy… could you just explain it to me in your own words P: Music, erm, doesn't have any borders erm it's different, music, for different countries, different areas, but it doesn't really have any… you know like you asked me my, er, ethnicity and my background music doesn't have that, it's just there's Western music, there's Asian music, there's all sorts of different music. With [Saif] it helps him with day to day living, erm, it relaxes him, soothes him. He listens to a wide range of music. We talk about [Saif] – from Western to South Asian to everything… to classical music… he listens to everything I: Is that within your home P: Yes I: Yes P: Yes. Erm… and here in school they do all sorts of music sessions I: Lovely P: Instruments. So since he was little, erm, he's been listening to music and instruments, been helped to play instruments, so music's been a massive part I: And so what do you think [Saif] gets out of the music therapy sessions P: He gets the joy… happiness… it soothes him, relaxes him. Erm, you know yourself, when you listen to the radio in the car or put a CD on or an mp3 you know, you do that… it just takes your mind takes you away somewhere pleasant and nice, if you've been on your holidays, if there's been certain CD or certain songs that have been on and you play em back I: Mmmm P: It's memories as well, for happy times, parties. Erm… when he's been to parties er here at school or other places, er, he associates music with that as well. Films, he goes to watch films, er, at the cinema and music from there we play that, so it takes him back I: Yeah P: So it's massive, it's erm… massive. It's really important for him and for us I: And you er did you attend some of the sessions? P: I did yeah I: And what do you think you got out of P: just I: being part of that session P: Just seeing that, erm, how happy he is and how Caroline's been working with [Saif]. The joy that [T – said class teacher's name by accident], sorry Caroline's got and what the joy that [Saif] got together I: Yeah P: He's a lovely boy I don't know if you've seen the videos	Music can change a person's mood MT sessions foster positive feelings *P now has a soothing, relaxing tone as he talks about these emotions in his son* Music can evoke memories from a place, holiday, party; for [A] as for anyone Parents select music they play to [A] on purpose to evoking memories of happy times, cinema etc. Music important for child and family P identified positive emotion – joy – in [A] and MT while they were together in MT session, and P shared that when he saw his son was happy Parental pride in his son I aware of not knowing all the information, at a slight disadvantage? Previous experience of MT

I: No, no I haven't P: After this interview, erm you know, have a look to see I: Oh thank you P: And then you'll get an idea cos this'll make more sense then	
I: Yeah, I'm sure Caroline will understand more what you're talking about… P: Yeah I: …as well	Recognition of MT as linking to school's approach – elements of structure, systematic approach
I: Erm, yeah, so in terms of the music therapy sessions, what did you think about Caroline's approach	Positive description of music therapy experience Recognises person centred element
P: Brilliant, brilliant I: Yeah? Ha ha P: See what you've got to understand is, erm, I know about music therapy we've worked with music therapists in the past I: Mmm..	Working on [A]'s level
P: So what Caroline was offering was nothing new I: Yeah P: So we knew exactly how, and, obviously coming in to school when the children come in there's a certain routine of coming in I: Mmm-hmm P: having a hello song, and having, er, structured lessons and activities and that's what she brought, so it's very professional, but very detailed in she, er, engaged with [Saif] on his level. And worked with him, and [Saif] with, it was a two way…	Noticed and found aims-orientated approach successful
I: Yeah. And do you think it was a, erm, a successful way of working towards aims that were… P: Yes I: …specific to [Saif]'s needs? P: All the aims that, erm, Caroline had put down and identified, they were met. So that's really encouraging I: Right P: I'm quite happy I: And did you, did you like her use of voice, of instruments, of… P: Everything I: Did you think she made a good selection in the different ways that she communicated P: Brilliant, all the, yeah, the only thing I would say is that, er, [Saif] likes the harp	Identified [A]'s preference for harp This instrument not available this time
I: Oh right P: So when he was very poorly in Manchester and in Leeds the music therapist in Manchester and in Leeds hospital they had the… harps I: Ah OK	Noticed and appreciated range of instruments; pitches, timbres provided
P: And he just loves that harp music I: Yeah P: Erm…	Complements professionalism of MT, personal style,
I: So that's quite a specific	Appreciated being asked for permission –

P: Yeah I: Specific to [Saif] isn't it P: Yeah, so I: That would mean…	respectful, professional attitude of MT
P: So obviously Caroline's only got so I: Yeah P: So much space in her car… and she can't be lugging a harp around I: [laughs]	He fights for his child and his needs – he knows better than anyone
P: But he was playing with the guitar so… he likes stringed instruments as well as…	Similar outlook of all MTs they've met
I: Lovely 8.28	Suggests drive to be an MT comes from passion about music. Also caring and passionate
I: And what did you think of Caroline as a therapist P: She's amazing, she's absolutely fantastic. She's very professional and down to earth and, erm, she's engaged with us and the er, and [A]. She's asked our permission for everything from day one. Ahhhm, and I jumped at the chance I: Yeah P: Cos I know what my boy wants and… I: Yeah	Found these positive personal attributes in other MTs they've met
P: …needs	Advocate – role of fighting for his child's needs
I: And do you think, erm, your experience of music therapy with Caroline and in the other places have all been similar, or have you seen differences between the different music therapists P: Very similar, the outlook is very similar. It takes somebody very caring and very passionate about music to actually do music therapy with disabled children. And she fits, yeah, she's been like the other music therapists that we've had, very er, very kind inside and having a big heart and wanting to give… er… the more she's given, the more [Saif]'s given back, and we've given I: Mmm-hmm. You seem to have a very positive impression of music therapy as a whole from your previous experience and… P: I can only go on my own personal experience I: Yeah P: And I can only go on the experiences that [Saif] has had. I'm his father, I'm his advocate I: Yeah of course P: Erm, I advocate for everything for him and his siblings, erm and we've tried to get music therapy erm, from other places and it hasn't really worked for funding reasons things like that I: Have any of his siblings had music therapy as well P: Er… not, not like this, no I: No. And have you used a lot of other therapeutic services? P: Well, we, we do, yes. Again it depends, yes, we've had aromatherapy, we've had other	MT equivalent to aromatherapy, hydrotherapy MT sessions has led parents to increase use of music in the home Describing other live music-making in school as 'doing music therapy'

things but there's a hydrotherapy pool here as well. Erm, [Saif]'s been quite poorly over the last two years – he was in hospital a year, erm… so he's been off school for two years so we're trying to get him back and this has helped him get back in to school	Parents trying to do everything they can for their children
I: Super	
P: So this is helping	
I: Erm, and do you think seeing the music therapy process, has that changed in any way the way you used music with [Saif]?	Use of music to change emotional state
P: Not really, because we knew most of the things	
I: OK. Or from the music therapy that you'd seen previously	
P: Yeah, yeah we have	
I: Do you think you've adopted some of the skills that they use	Parent wants more MT. Using this interview to make a plea for more MT.
P: Yeah we… maybe we didn't use music as much before but erm... but we've met other music therapists we've met quite a few now. They have groups they come here into school as well like Shebang, they do a lot of music therapy song and dance	
I: OK	Complementing MT again
P: Er, [A] and his siblings go to the theatre to watch plays and things like that, so yeah, we've tried to just give them everything	*Feel of interview much more relaxed now. More listening, less interrupting (from both)! Can hear smiles and laughter in voices*
I: Yeah, just to really incorporate it all	
P: Yeah. When when we're in the bus, we've got a massive van which they call the bus, my children, we try and play different music	D
I: Ah OK	
P: There as well, so it's a big part. It just calms and soothes them down	
I: Yeah. I have another question but I think I know the answer to this!	
P: Go on then	
I: Would you use music therapy in the future if it were available	
P: I I well yes of course!	
I: [laughs]	
P: We would like more therapy please I have three children and I'd like it for my other two as well and for [Saif] more… cos it helps him on a, day to day, with his living	
I: Mmm	
P: It's massive, it's really helpful	Use of music to influence mood; soothe
I: Yeah	Done very consciously
P: And Caroline's been amazing… I can't say enough about Caroline.. she's wonderful, she's amazing, er.	
I: Yeah.	
P: So yeah, so, yes more please if there's any way of…	
I: Yeah	
P: So she's made a big difference to us	
I: That's super	
P: And to [Saif]	

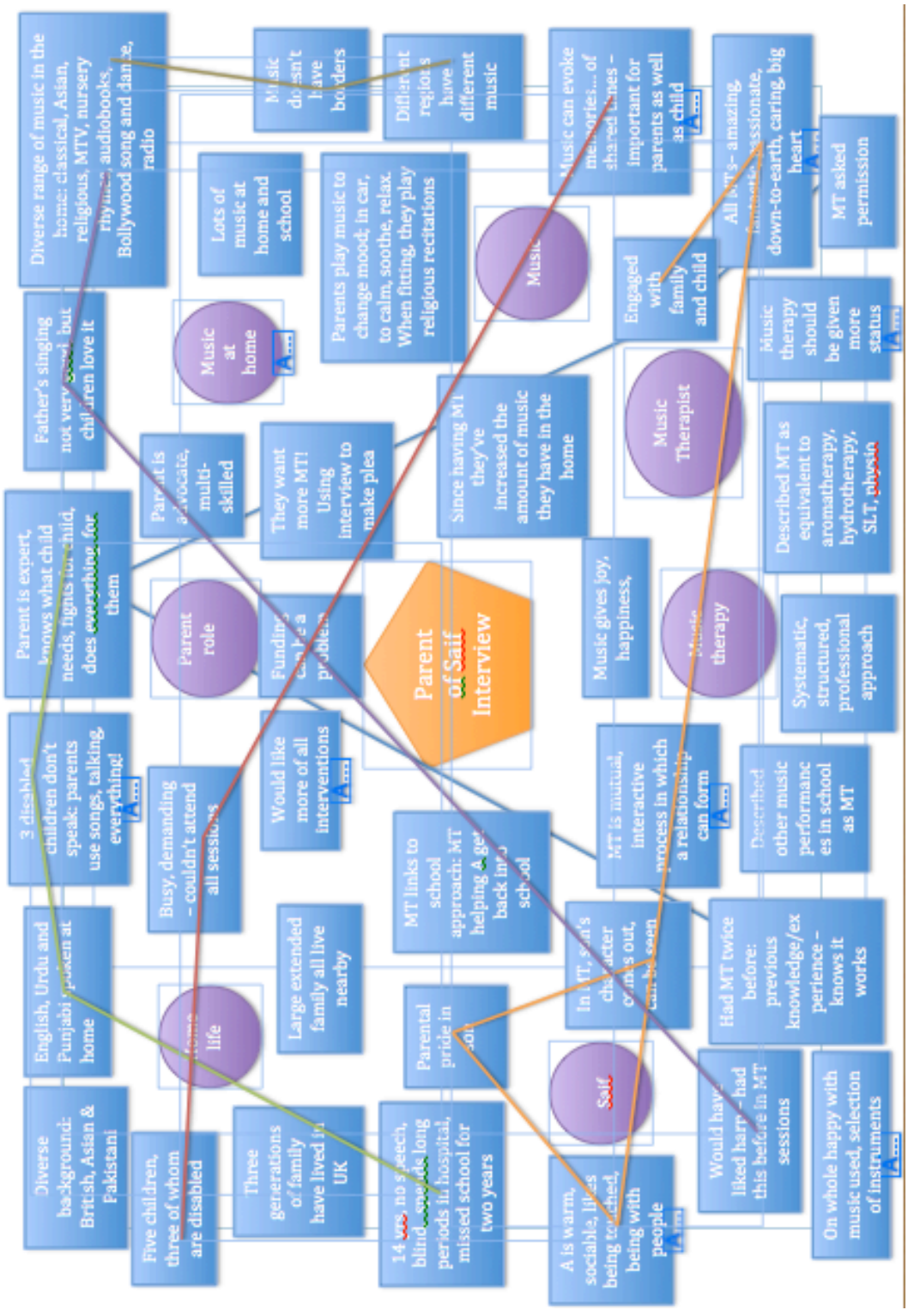
I: And so if I could ask you to think about in the home, and just to give some quite specific examples P: Yep I: Caroline would like to know what sounds are in your house and are typically heard, so, music played, or TV or DVDs, any other kind of music P: Yeah yeah so obviously there's the radio, CDs I: And what sort of stations would you listen to on the radio P: It depends, classical, Asian channels, classic fm, erm radio 1. It all depends what's on I: Oh sure, it's really nice to get the whole picture P: Sure I: It might seem like, erm, a generic question, but… P: No it's not really, because at the end of the day, if he's had a, er, tough day at school and he's quite tired, we put something soothing on I: Mmm P: So, like classic fm if there's something quite soothing on there but if something's zzzz [lively, buzzing vocal sound] on classic fm we're not going to put that on so it all depends on how he is, to what he'd like I: Ah so you say you really select the music you're going to play to reflect [Saif]'s mood P: That's right. So how he is. So like there's so many music channels on the TV now from MTV to all sorts. There's a wide selection so it's not just one genre there's so many different… so it all depends on how he is… ahm if he's fitting then we, we'll play, erm, the Qur'an. We've got that on a CD, that's our bible for Muslims, and then the Qur'an's recited or it's on an mp3, you know just put it in a USB and you've got… So we've got different things, we've got nursery rhymes, we've got books with, er CDs I: And I know Caroline will ask which books, which CDs P: Cars, Toy Story, Cinderella, all sorts of things like that so… I: OK P: So there's music in the background and there's noises. So it's massive I: Yeah P: It's massive, it's all the TV channels, all the radio channels, all the CDs, music… so it's everything, we use music quite a lot I: And which languages are spoken in the home? P: Erm Urdu, Punjabi, mostly English I: Mostly English. And which language do you speak to [A] and your children in ? P: In both, in Urdu or in English I: And what about between each other, how do they communicate?	Religious music for when he's fitting – religious dimension provides additional support? Music a big part of life. Music used a great deal of the time Wide selection of music in the home Use both English and Urdu with children Use many different means of communicating with children Parent is expert, multi-skilled by necessity Parent is advocate Child likes mix of music (reflecting diversity of cultural background) Parent highlights different sound qualities found outside Warm, social characteristics of child's

P: Er the children? I: Mmmm [assent] P: Erm, its' mostly English I: Mostly English. Lovely. And… P: [Saif] can't talk, nor can [sibling A] or [sibling B], so they babble or cry or smile, and the other two speak in English I: OK, and how do you, erm, interact with [Saif] in terms or talk, do you sing songs… P: We do everything, we do everything I: You do it all [with a smile] P: We do it all [with a smile I: [laughs] P: Yeah, because you have to do it, as a parent, erm, of these children, because that's what's needed I: Mmm-hmm P: So I have three disabled children that go to this school and obviously I'm fully committed to my children, to advocate for everything and we try and communicate in the best way possible to get the most information out of them and to reassure them I: And in terms of [Saif] erm what do you think are his favourite things to watch or to listen to P: Erm, he listens to, he likes CBBies, all the children's programmes. Erm, he watches Bollywood films, and there's a lot of song and dance and music in there. Erm listens to the radio. He likes to be out when it's like this just out in the garden just listening to the birds singing, erm yeah. I: Yeah there's lots of sounds… P: Lots of sounds, he likes that. He lies to be with people, he's very social. He's very gentle and he just likes to be held, people touching him, holding him. "Couse he's blind he touches people's faces, he's very social, I guess again I'll say that. He's very interactive, tactile, he likes people. I: Mmm, and in terms of this research project how have you found the experience of being involved in the music therapy sessions P: How have I found it or… I: In kind of a practical, logistical sense really. Attending the sessions with your child… P: I haven't attended many because obviously the logistics of having three disabled children… every bit or time you get to yourself you want to just… I: It's precious P: It's precious [smiles], erm, but we've accommodated Caroline at home I: Mmm-hmm P: And it's been fine I: Yeah so you've kind of found a way around it really to fit in with your circumstances… P: So we've made it work, er, to fit in I: So coming in to school, that wasn't really…	personality Home life busy, difficult to attend all sessions They want more music therapy Highlights particular value of MT for children like his Funding issues prevented previous MT sessions

P: He wasn't in school then I: Oh cause you… is that when he was poorly… P: He's been off school for a year, he's only been back into school for an assessment period before Easter for a month, and that was only half days I: Uh-huh	
P: And he's coming in for another month half days now I: Is that to build back up to? P: It's difficult because it's to see his needs I: Yeah. That's fine P: Yeah I: And normally, er do you have quite a lot of involvement in the school or?	Again, linking MT to hydrotherapy, aromatherapy, also speech and language therapy
P: Yes I: Yeah you do so it's quite a familiar environment for you to come to P: Yeah I: Lovely, well thank you very much for …	Comment seems to indicate recognition of extra depth behind approach Need for better understanding of music therapy
P: No thank you… I: …taking the time to P: …and I hope it makes a difference, er, if we can be offered more we'd be quite happy to have some more therapy I: Yeah P: And it's really important for children like [Saif] to have this music therapy. It should be part of the curriculum and it should be part of the therapy that's offered like physiotherapy, music therapy should be I: Yeah P: Like that I: It's interesting to hear different people's perspectives and I think that's one of the things that Caroline wants to touch on, is er, how much of a want and a need there is for the service because I know it's difficult for music therapists to find work P: Cause it's funding, funding is a big issue	Recognition of effectiveness of MT Parent singing music to child – quality of singing not as important as the relationship and the fact that they are singing
I: Yeah P: Erm we, had, er, a music therapist in Leeds made contact with us and she came to see the children in school, but then nothing came of it and when I asked later on it was about funding, so nobody really tells you how the funding works or how… and it seems it's a bit wishy washy this music therapy, doesn't make a difference… but it makes a massive difference, same as hydrotherapy, aromatherapy… music therapy I think it fits in to that I: Yeah	Same songs over and over, child hums along (big step for her)
P: Like speech and language I guess it's part of that. I think it should be seen as that I: Mmm.	Complementing the MT
P: And it's taken too lightly as if it's just some… I: Yeah I suppose it's not well enough understood P: Yeah, it's not well enough understood. And,	MT makes a difference to the family

and er maybe people don't understand it as well, but people like me do because I: You've seen it P: We've seen it with several different people now. That's why we know it works I: Yeah P: So thank you again, and thank you… I: Oh no, no, thank you P: …for offering this therapy to us I: Well there's one question I've missed… Do you play a musical instrument or sing? P: I don't. I sing, yeah, I sing to my children, er, it's not very… you know it's out of tune and it's I: Oh that's fine! [laughs] We can't all sound like Caroline P: Yes I do sing, I do and they love it. They love it. I think it's their father singing that's what… I don't think they care how I sound, or what I'm singing, it's that I am singing I: Yeah, definitely P: Ah, and I think that's what makes, er, my daughter… every night I've got to sing her Twinkle twinkle little star, or wheels on the bus, erm, she won't go to bed unless I've sang that so many times, and she'll hum, she might say the odd [sings] hmm-hmm-hmm. But that's all I get, but that's good enough for me I: Yeah, yeah P: And she's doing that… [pause] I: Lovely P: So yeah, so yeah. We do sing, but obviously it's out of tune, it's not… but they like it though and that calms them down, reassures them. So yeah. I: Is there anything else that you'd like to share? P: No, just that Caroline has been amazing and I can't thank Caroline enough. And erm, you know all kudos to her and I hope she keeps doing what she's doing for as long as she can, and she makes a massive difference for us so, we can't thank you enough, so thank you, I: Ah, that's very kind P: No, it's the truth I: I'll pass that on. I don' wan to keep you though, I'm aware of the time. It's 12.28 P: I've got to go. Thank you I: No, thank you. Nice to meet you [Saif][calls him son's name by mistake] P: [S] I: [S]! Sorry [S]! P: No it's alright! Call me anything [laughs] I: Sorry [S] P: Bye [voices fade moving out of the room]	

Appendix nine: Spider diagram of themes with linking lines (Parent of Saif)



The different coloured lines relate to different themes:

Orange	Emotional elements to music therapy
Green	Communication and language
Red	Benefits of music therapy for parents
Blue	Parent is expert
Brown	Music and culture
Purple	Importance of relationship